

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

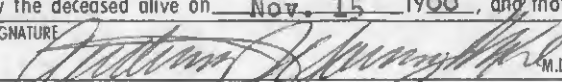

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15155

CERTIFICATE OF DEATH

15153

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13yr9mth28dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>3713 Claremont Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Angelina</b> Middle <b>Albano</b> Last			4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 66</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1920</b>		9. AGE (In years last birthday) <b>46</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dressmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY? <b>Italy</b> ✓
13. FATHER'S NAME <b>Francis</b>			14. MOTHER'S MAIDEN NAME <b>Mary Mazzone</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma w poorly differentiated,</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>left breast, with generalized metastases</b> DUE TO (c) <b>2yrs. 9mo.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>Jan. 17, 1953</b> to <b>Nov. 15, 1966</b> , that <del>(he)</del> (we) last saw the deceased alive on <b>Nov. 15 1966</b> , and that death occurred at <b>4:15</b> M, from causes and on the date stated above.					
22a. SIGNATURE 		a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Ba No. Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph J. Zannino, Jr.</b>		ADDRESS <b>263 S. Conkling St.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 30 1966</b>	25b. REGISTRAR'S SIGNATURE 

25151

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15156					15154				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21212 Rogers Forge</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>					d. STREET ADDRESS <u>637 Regester Avenue 03-1</u>				
3. NAME OF DECEASED (Type or print) <u>Birdie Carter Alley</u>					4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3, 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolteacher - Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
13. FATHER'S NAME <u>George Washington Alley</u>					14. MOTHER'S MAIDEN NAME <u>Lucy Landon Taylor</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture Hip and Operative Repair</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 weeks</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Pt fell at home 9/20/66 fracturing her hip.</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>Sept 20 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Baltimore Maryland</u>		20g. (City or town) (County) (State) <u>Baltimore Maryland</u>	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>22 September 1966</u> to <u>17 Nov 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>about 4 Nov 1966</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert Zadek</u>					22b. DATE SIGNED <u>18 Nov 66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert Zadek, M.D.</u>					22d. ADDRESS <u>220 W. Cold Spring Lane 21210</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>NOV 23 1966</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				





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15157 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15155 CERTIFICATE OF DEATH

15155

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Halethorpe</del> <b>Baltimore #27</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1715 Arbutus Avenue</b>		e. STREET ADDRESS <b>1715 Arbutus Avenue</b>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARA (CLAUDINA)</b> Middle <b>ANDREONE</b> Last <b>ANDREONE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1879</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY <b>Italy</b>		13. FATHER'S NAME <b>Francesco Tarantelli</b>	
14. MOTHER'S MAIDEN NAME <b>Maria Bonolis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-10-5589 D</b>		17. INFORMANT Address <b>Mr. Fortunate Andreone, 3001 Acton Rd. #34</b>	
18. CAUSE OF DEATH { Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident, Hemiplegia right side</b> (b) <b>Hypertension, arterio sclerosis, myocardial</b> (c) <b>Semi lily</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      OUE TO      OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>10/31/66</b> , 19____, to <b>11/5/66</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/31/66</b> 19____, and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Andres E. Calas</b>		22b. DATE SIGNED <b>11/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andres E. Calas</b>		22d. ADDRESS <b>6411 Frederick Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/8/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. - Baltimore, Md.-14</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15158					15156						
Items 12, 13, 14 from 12/5/66 mb											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>G.B.M.C. Towson</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>G.B.M.C.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30.4</u> d. STREET ADDRESS <u>3503 Sequoia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Frank N.M.N. Angelozzi</u>					4. DATE OF DEATH <u>11/29/66</u> Month <u>11</u> Day <u>29</u> Year <u>19</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/1883</u> Month <u>7</u> Day <u>13</u> Year <u>1883</u>		9. AGE (in years last birthday) <u>83</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Contractor</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Nicola Angelozzi</u>					14. MOTHER'S MAIDEN NAME <u>Maria Granieri</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>215-28-1082</u>		17. INFORMANT <u>Maria Angelozzi</u> Address <u>3503 Sequoia Ave.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> 433X DUE TO (b) <u>Arrial fibrillation, cerebral embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>7 days</u>										INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> , 19 <u>66</u> , to <u>11/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>66</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Juan L. Roque</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/29/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>					22d. ADDRESS <u>6701 N. Charles St. Balto 4.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>12-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR <u>Charles Judge</u>					ADDRESS <u>4600 Liberty Hghts. Ave.</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15159

## CERTIFICATE OF DEATH

15157

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <u>03.1</u>	
c. LENGTH OF STAY IN TB <u>Life</u>		d. STREET ADDRESS <u>418 Fonthill Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>ANGER</u> Last <u>ANGER</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 27, 1878</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS ANGER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE SCHUCHMANID</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Fred. W. Anger</u>		Address <u>33 Edmondsan Ridge Rd #2228</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Cerebral thrombosis multiple</u> 4221 DUE TO <u>② Hemiplegia left</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>③ Arteriosclerotic Cardio Vascular Disease with Congestive Failure</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>9/18/65</u> , 19 <u>  </u> , to <u>11/8/66</u> , that (I) <u>  </u> saw the deceased alive on <u>11/7/66</u> , 19 <u>  </u> , and that death occurred at <u>1:50 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W.E. McGrath</u>		22b. DATE SIGNED <u>11/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath</u>		22d. ADDRESS <u>1303 Frederick Rd Catonsville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/11/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Louison PK</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>E.S. MacNabb</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>	
ADDRESS <u>301 Frederick Rd Balt 28, Md</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03128

22161

1. General Information

7-21-77 10/10/77

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15160

CERTIFICATE OF DEATH

15158

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<u>Baltimore County Hospital</u>		<u>3624 Milford Mill Rd</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
<u>OSCAR BAKER</u>		<u>11 - 18 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
			<u>10/31/1885</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Balt. Co. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Henry Baker</u>		<u>Sarah Guhrman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>			
17. INFORMANT		Address	
<u>Mrs. Lula B. Baker</u>		<u>Balt. 21207</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-11-1966</u> , to <u>11-18-1966</u> , that (I) (we) last saw the deceased alive on <u>11-18-1966</u> , and that death occurred at <u>3:35 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Cervero</u> M.D.		22b. DATE SIGNED <u>11-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>8629 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>11/21/66</u>	<u>Mt. Olive</u>	<u>Randallstown, Md</u>
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
<u>Loring Byers-8728 Liberty Rd. Randallstown</u>		<u>NOV 22 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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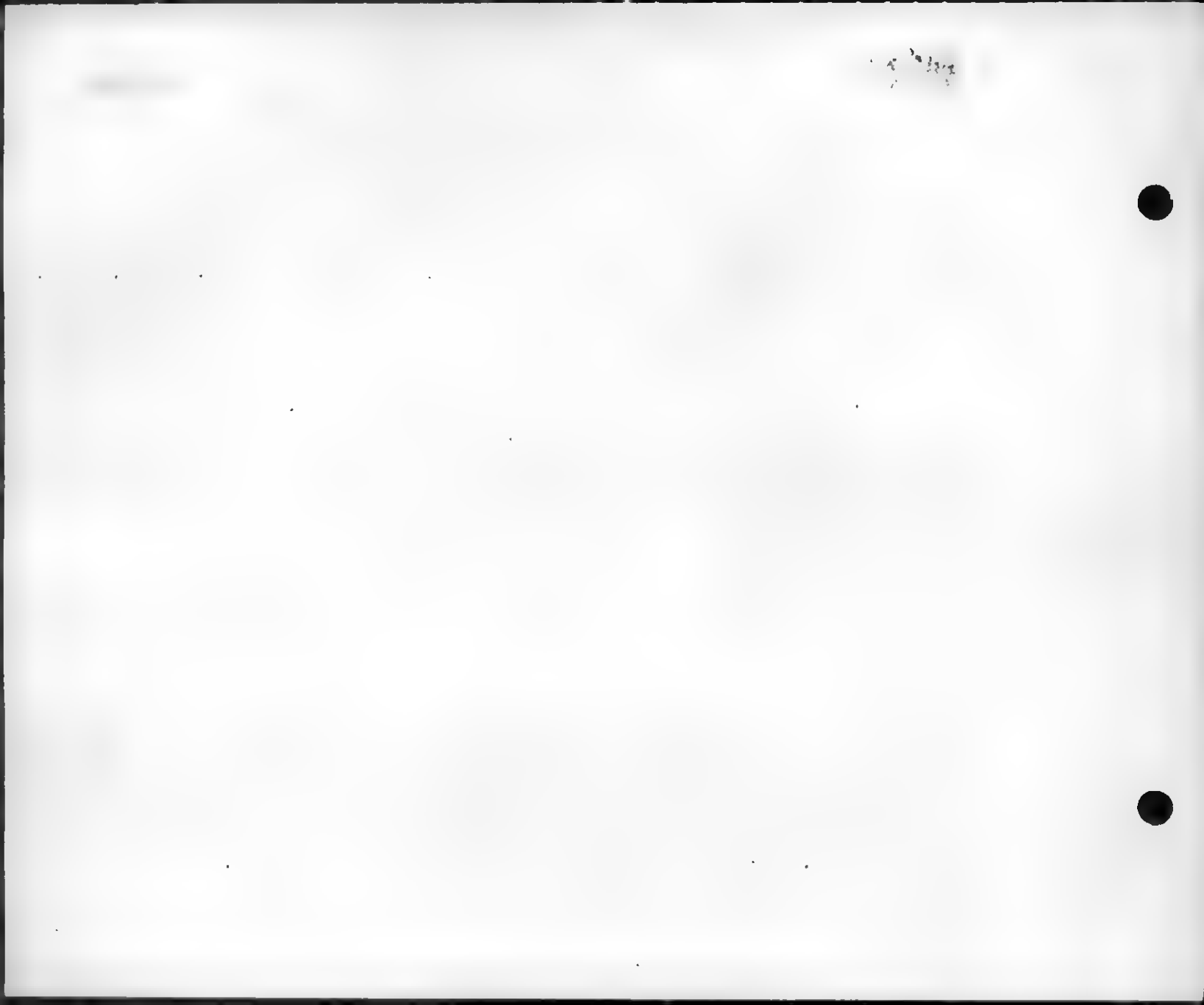
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
15161					CERTIFICATE OF DEATH					15159				
1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armacost Nursing Home</b>					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13-3</b> d. STREET ADDRESS <b>9 E. Chase St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3 NAME OF DECEASED (Type or print) First <b>Theodocia</b> Middle <b>Burr</b> Last <b>Baker</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1966</b>									
5. SEX <b>female</b>		6. CO. OR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>23 Nov. 1869</b>		9. AGE (In years last birthday) <b>97</b> yrs		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>2</b> Hours <b>—</b> Min <b>—</b>		11. IF UNDER 24 HRS Hours <b>—</b> Min <b>—</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. Work-</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York City</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>George H. Potts</b>					14. MOTHER'S MAIDEN NAME <b>Helen Hard</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO <b>224-62-1308</b>		17. INFORMANT <b>Dr. B. M. Baker</b>			Address <b>9 E. Chase St. Balt. Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Myocardial Infarction</b> (b) <b>30 yrs.</b> (c) <b>Inst. Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>May 15, 1965</b> , to <b>Nov 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 25, 1966</b> , and that death occurred at <b>9:15 A.M.</b> from causes and on the date stated above.														
22a. SIGNATURE <b>Benj. M. Baker</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 Nov 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ben Baker</b>					22d. ADDRESS <b>9 E. Chase St.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>11/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ELMWOOD CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>NORFOLK, VIRGINIA</b>						
24. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME</b>					ADDRESS <b>6500 YORK RD BALTO. 12, MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed in 21 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**15162** **CERTIFICATE OF DEATH** **15160**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8558 Willow Oak Rd.</b>				d. STREET ADDRESS <b>406 Wrenleigh Dr.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Peter E. Balter</b>				4. DATE Month Day Year <b>Nov. 6 1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 12, 1903</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. School Bd.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ignatius Balter</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Yaunlayage</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>219-30-3483</b>		17. INFORMANT <b>Mrs. William Spicer</b>		Address <b>406 Wrenleigh Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>(Post Infarction)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b> <b>Obesity</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>11/6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/2</b> 19 <b>66</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James J. Nolan</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James J. Nolan</b>				22d. ADDRESS <b>1 Mallow Hill Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-10-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Witzke F.D. - 4101 Edmondson Ave.</b>				25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15163

MARYLAND STATE DEPARTMENT OF HEALTH

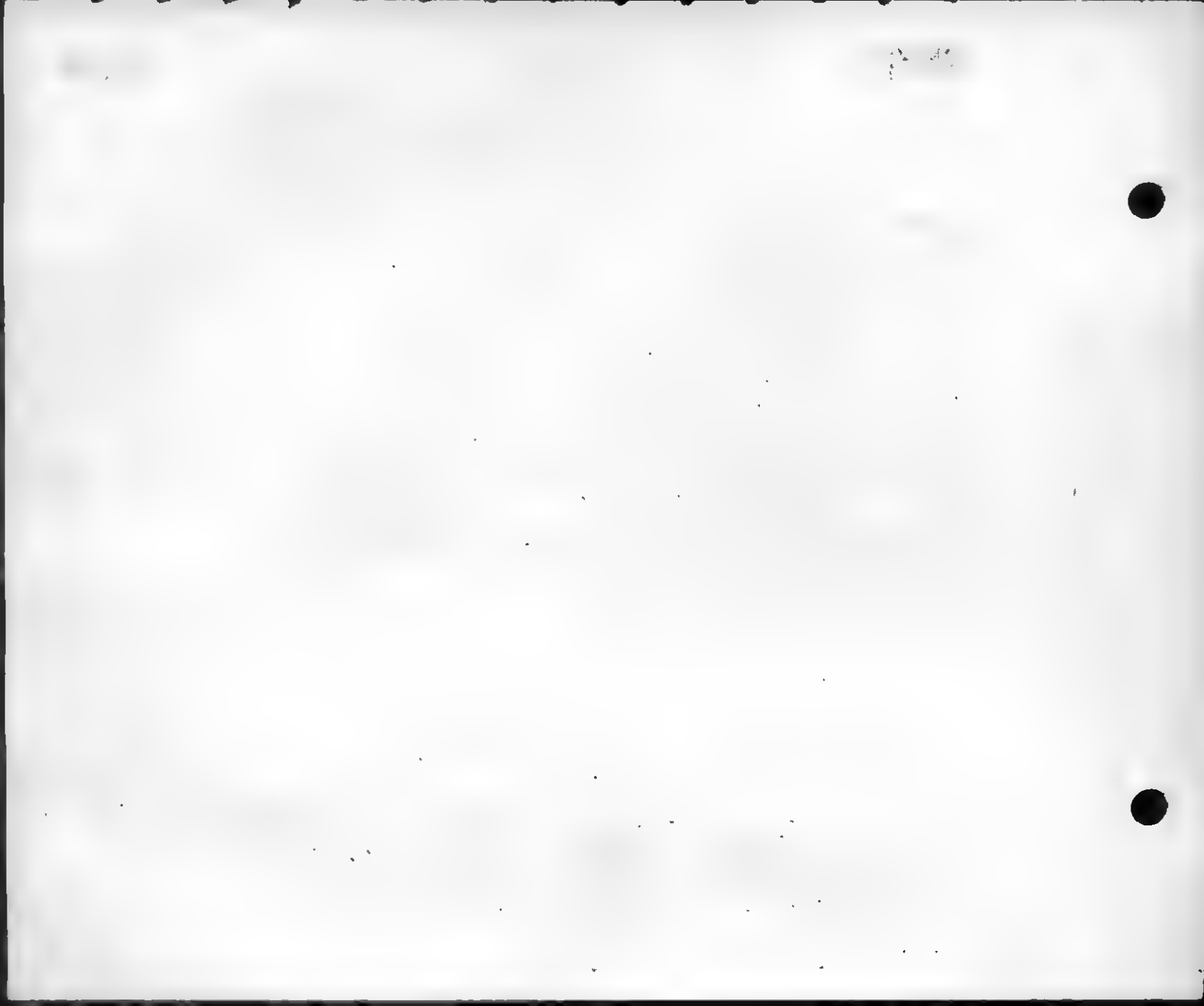
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15161

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greene Balto. Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>12 E. Seminary Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Janice Elizabeth Barclay</u>		4. DATE OF DEATH <u>11 30 19 66</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-30-19 46</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>30</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own-home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thurston Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Beth</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Resp. Failure</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 28, 1966</u> to <u>Nov 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 30, 1966</u> , and that death occurred at <u>10:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Denis Chan</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Nov 30 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>		22d. ADDRESS <u>GTB MC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem.</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns Sons Towson, Md 21204</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 1966</u>		25b. REGISTRAR'S SIGNATURE <u>W. Judge</u>	

MEDICAL CERTIFICATION





**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

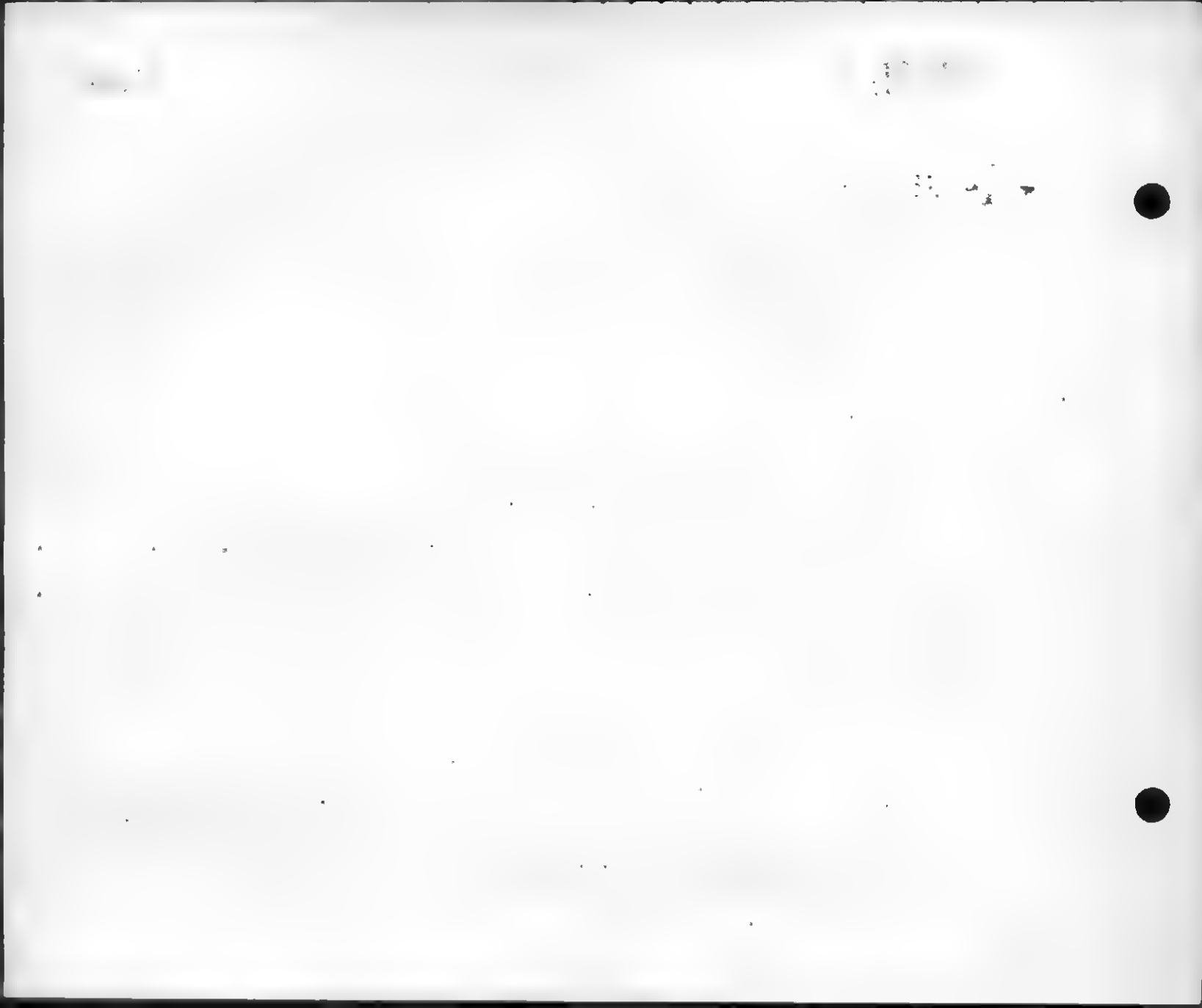
**15164**

**CERTIFICATE OF DEATH**

**15162**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights Maryland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>6103 Kingston Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Rose</b> Last <b>Barrett</b>				4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1966</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1916</b>		9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Henry DeForest Tuddle</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Rose</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b> DUE TO (c) <b>Arteriosclerosis, Generalized</b>							INTERVAL BETWEEN <b>sudden</b> <b>10 yrs.</b> <b>10 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Previous myocardial infarction (1964), 2) uremia, 3) bronchitis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>Feb. 10, 1959</b> to <b>Nov. 27, 1966</b> , that (1) (we) last saw the deceased alive on <b>Nov. 27, 1966</b> , and that death occurred at <b>7:10</b> M, from causes and on the date stated above.								
22a. SIGNATURE 				a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-27-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR <b>Krause Funeral Home 1216 S. Charles St.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 5 1966</b>		25b. REGISTRAR'S SIGNATURE 		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>15165</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15163</p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Baltimore</b> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b></p>				
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><b>Arbutus</b></p>			<p>c. LENGTH OF STAY IN 1b</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><b>Arbutus</b></p>			<p>d. STREET ADDRESS</p> <p><b>4557 Chapel Square</b></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><b>4557 CHAPEL SQUARE</b></p>					<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>Joseph</b> Middle <b>Thomas</b> Last <b>Barron, Jr.</b></p>					<p>4. DATE OF DEATH</p> <p>Month <b>November</b> Day <b>11,</b> Year <b>1966</b></p>				
<p>5. SEX</p> <p><b>Male</b></p>		<p>6. COLOR OR RACE</p> <p><b>White</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><b>June 4, 1898</b></p>		<p>9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Security Guard Retired</b></p>			<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><b>Pepsi Cola Co.</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country)</p> <p><b>Baltimore, Maryland</b></p>			<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>U. S. A.</b></p>	
<p>13. FATHER'S NAME</p> <p><b>Joseph T. Barron, Sr.</b></p>					<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Daisy Davidson</b></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p> <p><b>No</b></p>					<p>16. SOCIAL SECURITY NO.</p> <p><b>212-07-6420 A</b></p>				
<p>17. INFORMANT</p> <p><b>Mrs. Dorothy F. Barron</b></p>					<p>Address</p> <p><b>4557 Chapel Square</b></p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>'Metastatic' Melanoma</b></p> <p>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO (b) <b>Genetic</b></p> <p>DUE TO (c) <b>Jan 1963</b></p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>									
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>					<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>				
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <b>19</b></p>			<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		
<p>21. I certify that (I) (this hospital) attended the deceased from <b>10/14</b>, 19<b>66</b>, to <b>7/26</b>, 19<b>66</b>, that (I) (we) last saw the deceased alive on <b>7/26</b>, 19<b>66</b>, and that death occurred at <b>7/26</b>, 19<b>66</b>, from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE</p> <p><b>Robert B. McEadden</b></p>								<p>22b. DATE SIGNED</p>	
<p>22c. PHYSICIAN'S NAME (Type)</p>					<p>22d. ADDRESS</p> <p><b>3350 Wilkins Ave</b></p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>			<p>23b. DATE THEREOF</p> <p><b>11/15/66</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><b>New Cathedral Cemetery</b></p>			<p>23d. LOCATION (City, town or county) (State)</p> <p><b>Baltimore, Md.</b></p>	
<p>24. FUNERAL DIRECTOR</p> <p><b>Wm J. Tricker &amp; Son Inc</b></p>					<p>25a. REC'D BY REGISTRAR</p> <p><b>NOV 14 1966</b></p>				
<p>25b. REGISTRAR'S SIGNATURE</p> <p><b>Charles Judge</b></p>									

25 11

25 11





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

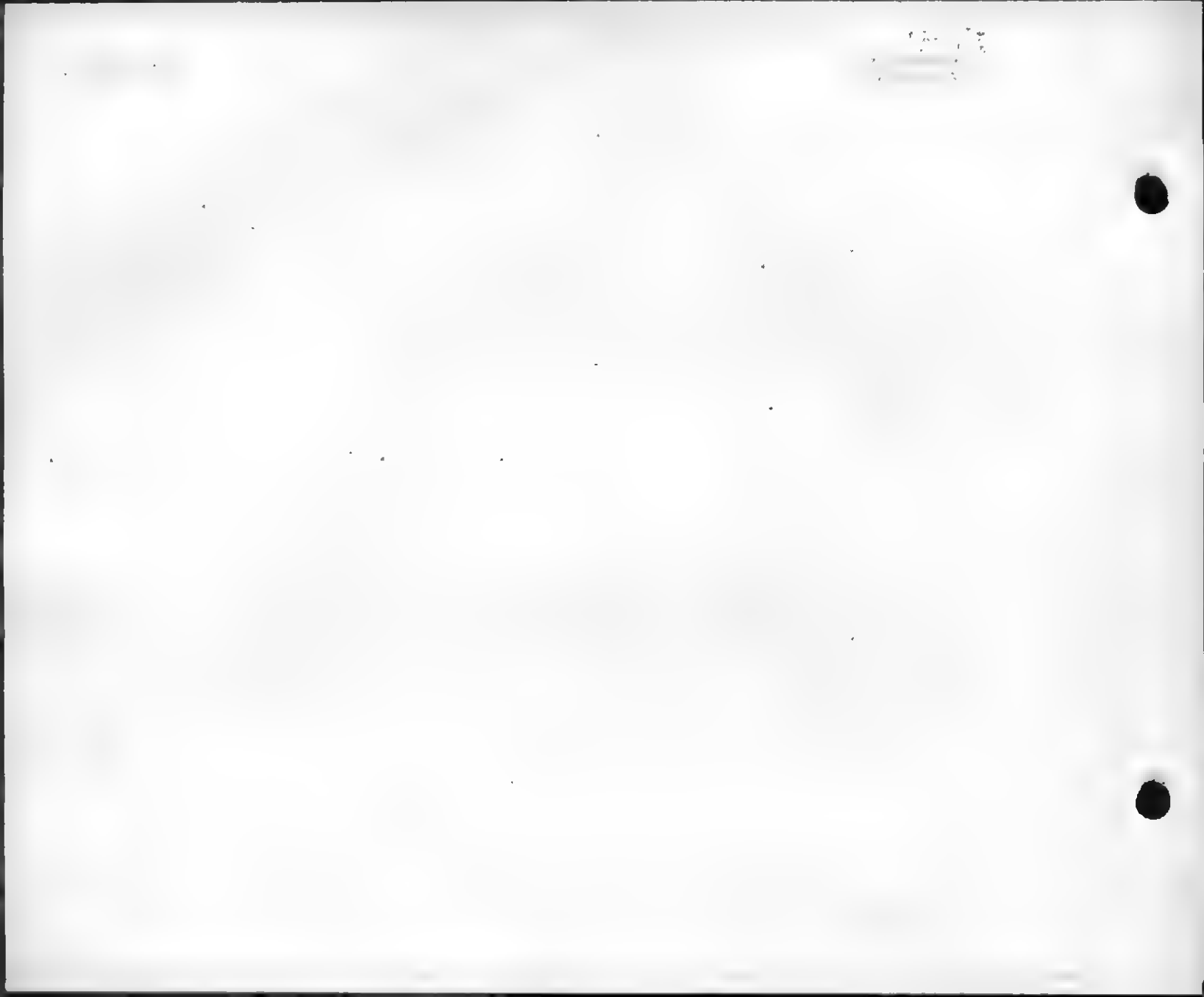
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15166

CERTIFICATE OF DEATH

15164

1 PLACE OF DEATH a COUNTY <u>Lutherville, Balto County, MARYLAND</u>			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				<u>Baltimore</u> <u>31-4</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor Nursing Home</u>			d. STREET ADDRESS <u>3925 Beech Ave.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
			<u>Wyman Park Apts.</u>		
3 NAME OF DECEASED (Type or print) <u>Thomas N. Bartlett</u>			4 DATE OF DEATH <u>November 14th, 1966</u>		
5 SEX <u>Male</u>			6 COLOR OR RACE <u>White</u>		
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8 DATE OF BIRTH <u>August 12, 1885</u>		
			9 AGE (in years last birthday) <u>81</u> yrs		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Executive</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12 CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Thomas H. Bartlett</u>			14. MOTHER'S MAIDEN NAME <u>Bishop</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>None</u>			16 SOCIAL SECURITY NO		
17 INFORMANT <u>Mr. Thomas R. Bartlett</u>			Address <u>E. Norwich, N. Y.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO <u>"</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senescent</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>61</u> to <u>Oct 6</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Oct 6</u> , 19 <u>66</u> , and that death occurred at <u>3:35 P.</u> from causes and on the date stated above					
22a. SIGNATURE <u>Ernest C Brown Jr</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22b. DATE SIGNED <u>Nov 15, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/16/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
				23d. LOCATION (City or town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Finkbeiner &amp; Son</u>		ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>NOV 17 1966</u>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 15165

15167

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shangri-La Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>406 Roanoke Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elma</b> Middle <b>S.</b> Last <b>Bates</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1881</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min <b>85</b>	11. IF UNDER 24 HRS Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min <b>85</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Stradley</b>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. ADDRESS <b>Miss Bertha Rehmann 406 Roanoke Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.V.D.</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerotic C.V.D.</b> DUE TO (c) <b>Arteriosclerotic C.V.D.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>yes 10</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March, 1966</b> to <b>Nov 16, 1966</b> that I last saw the deceased alive on <b>Nov 16, 1966</b> and that death occurred at <b>7:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3325 Frederick Av.</b> DATE SIGNED <b>11/18/66</b>			
ACTUAL SIGNATURE <b>John C. Pound</b>			
PHYSICIAN'S NAME (Type) <b>John C. Pound</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-19-66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.-4101 Edmondson Av.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 22 1966</b>	24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15168

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15166

1 PLACE OF DEATH a COUNTY <b>Balto.</b>		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a STATE <b>Md.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c LENGTH OF STAY IN 1b <b>DOA</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore Co. General Hosp.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>ESTELLA</b> Middle <b>M.</b> Last <b>BAUBLITZ</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-6-1905</b>
9 AGE (In years last birthday) <b>61</b> yrs		10 F UNDER 1 YEAR Months Days Hours Min	
11b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		11b KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>?</b>		14 MOTHER'S MAIDEN NAME <b>?</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>218-32-2859</b>	
17 INFORMANT <b>Mora L. Simmons, Box 135A, Rt. 5, Old Court Rd.,</b>		Address <b>Balto. 7, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>none</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>	
20c TIME OF INJURY Month Day Year Hour a.m. <b>none</b> p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>none</b>	
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.) <b>none</b>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, and an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D.D. Caples</b>		22. DATE SIGNED <b>11-28-66</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		6 Hanover Rd. <b>Baltimore, Md.</b>	
23a BURIAL (CREMATION REMOVAL) (Specify) <b>11/30/66</b>		23b DATE THEREOF <b>11/30/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM.</b>		23d LOCATION (City or Town) (County) (State) <b>BALTO, MD.</b>	
24 FUNERAL DIRECTOR <b>Paul E. Chenoweth, III, 3617 Chestnut Ave., Balto. 11, Md.</b>		25a REC'D BY REGISTRAR DATE <b>DEC 2 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

5000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15169

CERTIFICATE OF DEATH

15167

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3920 SUSANNA AVENUE 21133</b>		d. STREET ADDRESS <b>3920 SUSANNA ROAD 21133</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH R. BEATTY</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 1, 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-5-1908</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REALTOR</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAWRENCE BEATTY</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA -----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>214-03-1643</b>	
17. INFORMANT <b>MRS. CORNELIA M. BEATTY, 3920 SUSANNA ROAD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16-1X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Cause of lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> min. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>Nov. 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov. 1, 1966</b> , and that death occurred at <b>2</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Christian S. Mass</b>		22b. DATE SIGNED <b>11/3/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHRISTIAN S. MASS</b>		22d. ADDRESS <b>BALTIMORE NATIONAL PIKE &amp; ST. JOHN</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-4-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEMORIAL PARK</b>	23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>		25a. REC'D BY REGISTRAR <b>NOV 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

11

1951



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

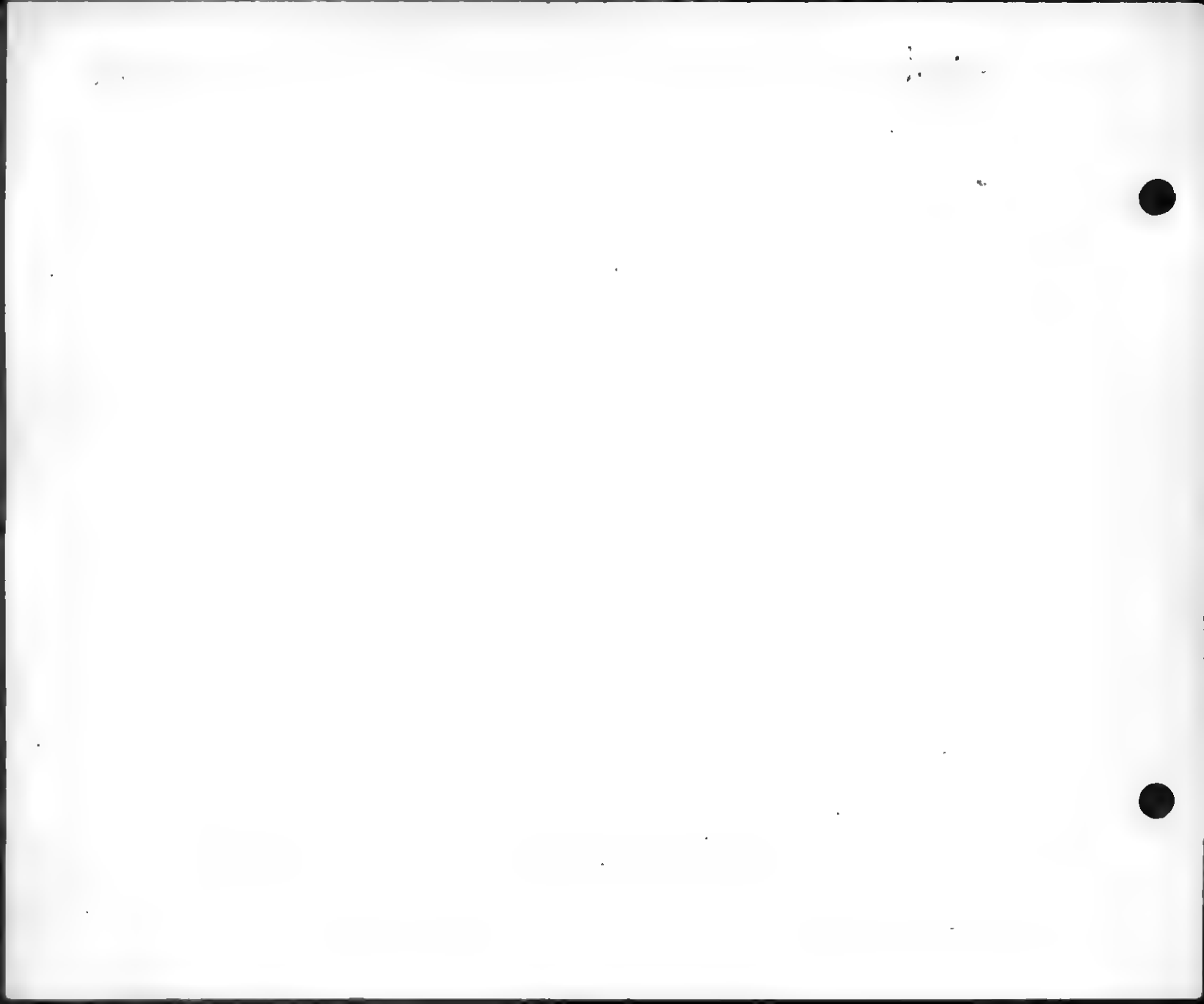
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15168

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>English Contact Consul</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>English Contact Consul</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4438 Fenor Road</b>				d. STREET ADDRESS <b>4438 Fenor Road</b>			
3. NAME OF DECEASED (Type or print) First <b>GARY</b> Middle <b>DENNIS</b> Last <b>BENDER</b>				4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1952</b>	9. AGE (In years lost birthday) <b>14 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Delroy M. Bender</b>				14. MOTHER'S MAIDEN NAME <b>Jeannette E. Hill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Delroy M. Bender 4438 Fenor Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shotgun wound of Head</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot self in head</b>					
20c. TIME OF INJURY Month, Day, Year <b>9:30 a.m. 11/11 19 66</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MED. CA. EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>11/12/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Amelia J. 1328 Dolphin Spring Rd.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

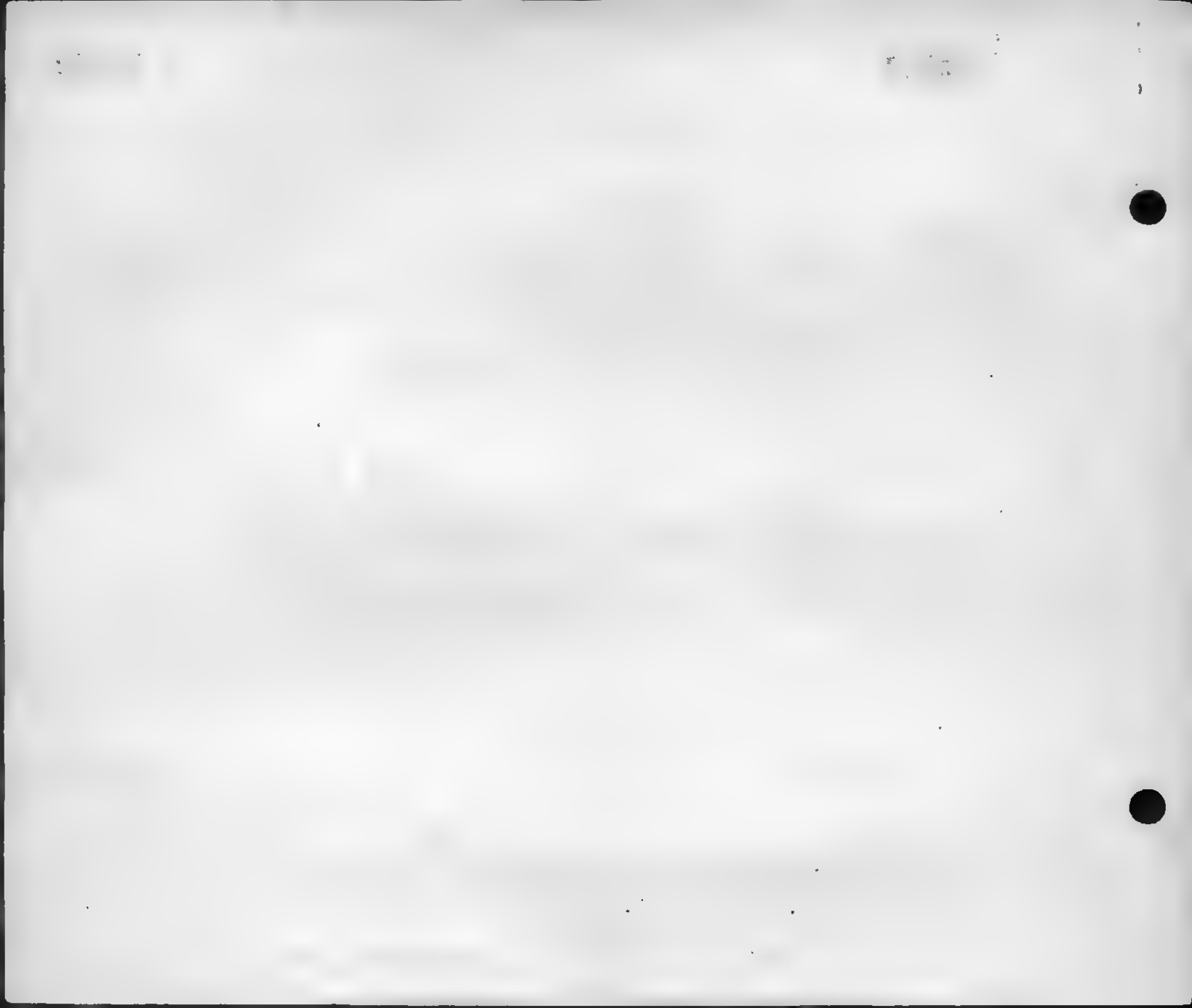
## CERTIFICATE OF DEATH

15171

15169

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> c. LENGTH OF STAY IN 1b <u>47 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stansbury Hill Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> d. STREET ADDRESS <u>Stansbury Hill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna Elizabeth Bennett</u> First Middle Last <b>4. DATE OF DEATH</b> <u>November 19 1966</u> Month Day Year				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>23 November 1891</u> Yrs. Months Days			
<b>9. AGE</b> (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.				<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Emmitsburg Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>John Adlerberger</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Nash</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Husband</u> Address <u>Same</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral vascular accident</u> DUE TO (b) <u>Hypertensive cerebral &amp; arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>25 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <u>46</u> (County) <u>66</u> (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 17 1966</u> <b>to</b> <u>Nov 19 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>17 November 1966</u> <b>and that death occurred at</b> <u>8:55 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Walter T. Kees</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>WALTER T. KEES</u>				<b>22b. DATE SIGNED</b> <u>19 November 1966</u> <b>22d. ADDRESS</b> <u>Cockeyville</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov. 22, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. John's Luthern Cem.</u>		<b>23d. LOCATION (City, town or county)</b> <u>Balto. Co., Md.</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burns' Sons, Towson, Maryland</u> ADDRESS				<b>25a. REC'D BY REGISTRAR</b> <u>NOV 23 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>William J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

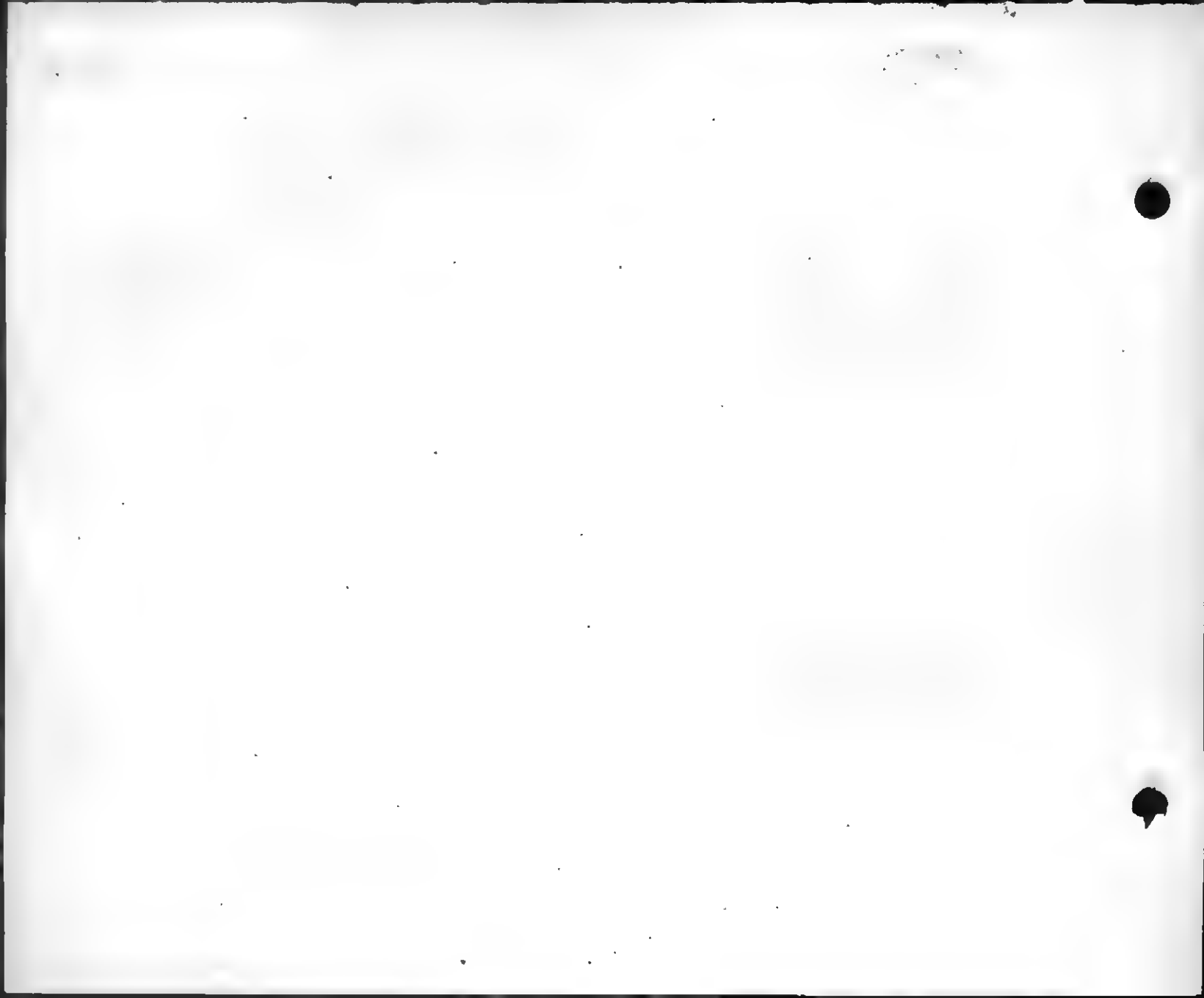
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

15172

15170

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>10 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SITONGRA LA NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights,</u> d. STREET ADDRESS <u>5907 Osage Street</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSEPHINE I. BENSON</u>			<b>4. DATE OF DEATH</b> Month <u>NOV</u> Day <u>27</u> Year <u>1966</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 30, 1890</u>	<b>9. AGE</b> (in years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Patrick Russell</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Beddow</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Mary I. Wheatley</u> Address <u>Same as # 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> (b) <u>Arteriosclerosis Heart Disease</u> (c) <u>Cerebral Arteriosclerosis</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u> <u>5+ yrs.</u> <u>5+ yrs.</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Decubitus Ulcers</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> (County) (State) <u>  </u>	<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 29, 1966</u> <b>to</b> <u>Nov 27, 1966</u> <b>that (II) (we) last saw the deceased alive on</b> <u>Nov 26, 1966</u> <b>and that death occurred at</b> <u>12:30</u> <b>M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>John N. Snyder</u>		<b>22b. DATE SIGNED</b> <u>11/27/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOHN N. SNYDER M.D.</u>			
<b>22d. ADDRESS</b> <u>6348 Frederick Rd. Baltimore Md</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>					
<b>23b. DATE THEREOF</b> <u>11-30-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Olivet</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Wash. D.C.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Matthewly 131-1166</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 29 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

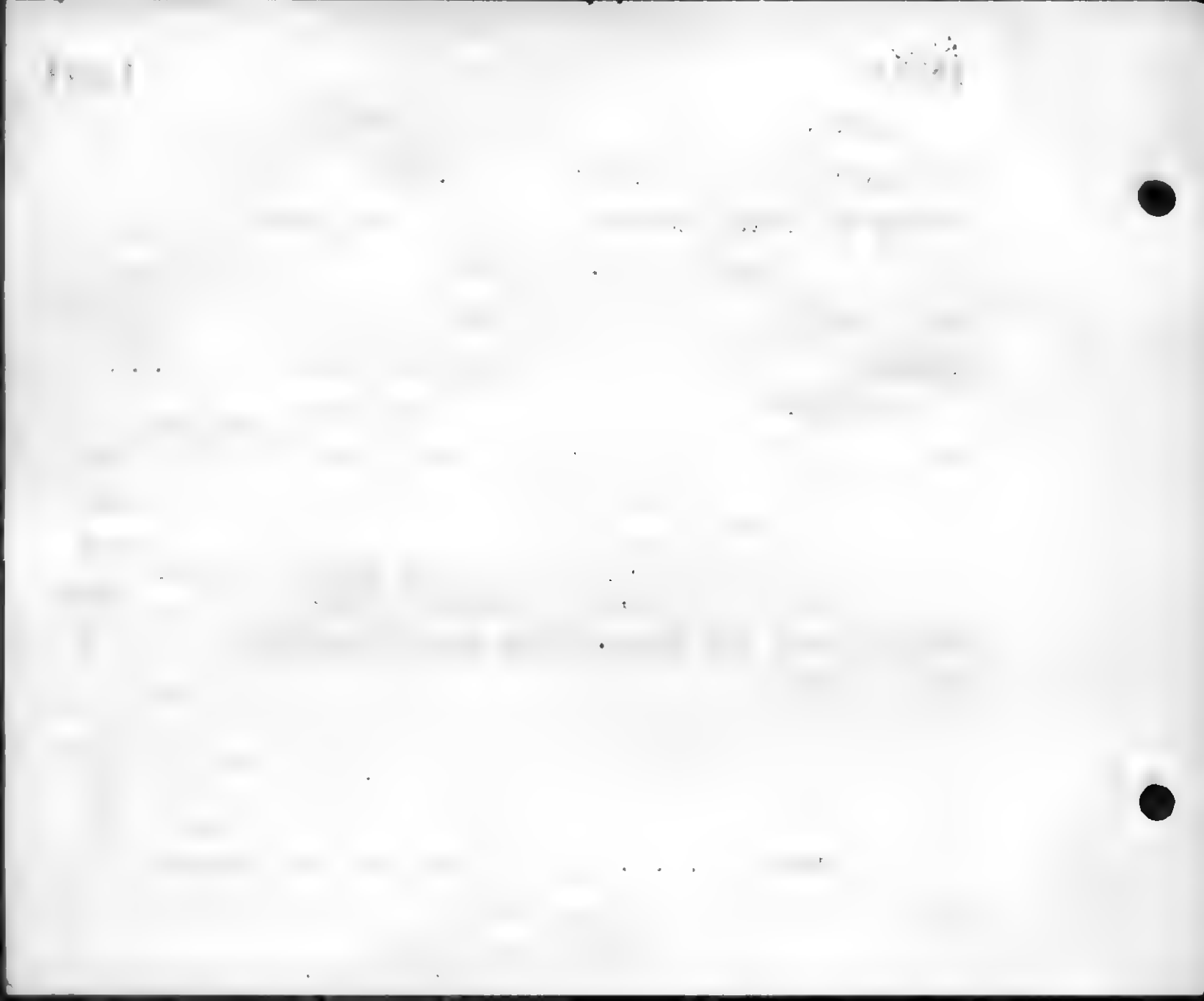
**15173**

**CERTIFICATE OF DEATH**

**15171**

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c LENGTH OF STAY IN 1b <b>16 DAYS</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d STREET ADDRESS <b>5123 LIBERTY HEIGHTS</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>EDGAR R. BEVERIDGE</b>				4 DATE OF DEATH Month Day Year <b>NOVEMBER 30 19 66</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 22, 1891</b>		9. AGE (In years last birthday) yrs <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPEFITTER</b>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>RICHMOND, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDGAR BEVERIDGE</b>				14 MOTHER'S MAIDEN NAME <b>MARY HERMAN</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW I</b>		16 SOCIAL SECURITY NO. <b>213 05 69 04</b>		17. INFORMANT <b>VETERANS ADMINISTRATION HOSPITAL FORT HOWARD, MARYLAND CLINICAL RECORDS</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>PULMONARY EDEMA</b> (c) <b>BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASIS TO LUNG, LYMPH NODES, LIVER AND KIDNEY</b>				Sydney Beveridge 5123 Liberty INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE. BENIGN PROSTATIC HYPERTROPHY</b>				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>11/14/66</b> 19 to <b>11/30/66</b> 19, that (b) (we) last saw the deceased alive on <b>11/30/66</b> 19, and that death occurred at <b>7:00P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>George Dudas</i> <b>GEORGE DUDAS, M. D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/1/66</b>	
22c PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR <i>Ellsworth Armacost</i> <b>ELLSWORTH ARMACOST</b>				25a REC'D BY REGISTRAR DATE <b>DEC 5 1966</b>		25b REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

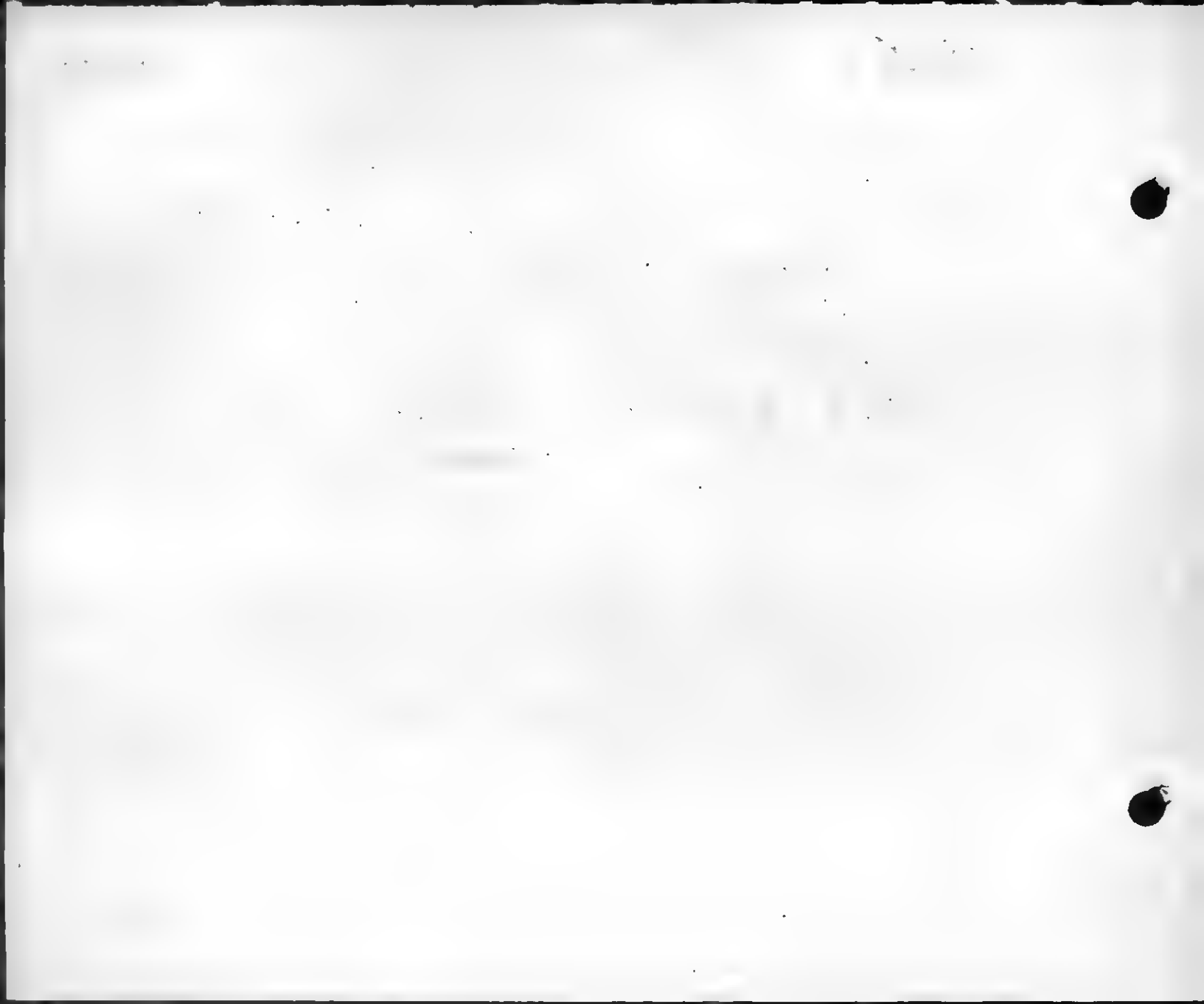
FOR STATE  
HEALTH DEPT.

15172

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15172

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>...</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTPOINT</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTPOINT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7721 WYNBROOK RD</b>		e. STREET ADDRESS <b>7721 WYNBROOK RD</b>	
3. NAME OF DECEASED (Type or print) <b>ALEXANDER W. BINKOWSKI JR.</b>		4. DATE OF DEATH <b>11 10 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-16-1913</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHECKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FREIGHT</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALEXANDER BINKOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE POPROK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>...</b>	
17. INFORMANT <b>THERESA BINKOWSKI</b>		Address <b>7721 WYNBROOK RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>adenocarcinoma of Bladder</b> 1 X 10 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Theo C. Patterson</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <b>11/11/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-14-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		23d. LOCATION (City, town or county) (State) <b>DUNDALK MD</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WERBER &amp; SONS INC 4015 CHESTER ST.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

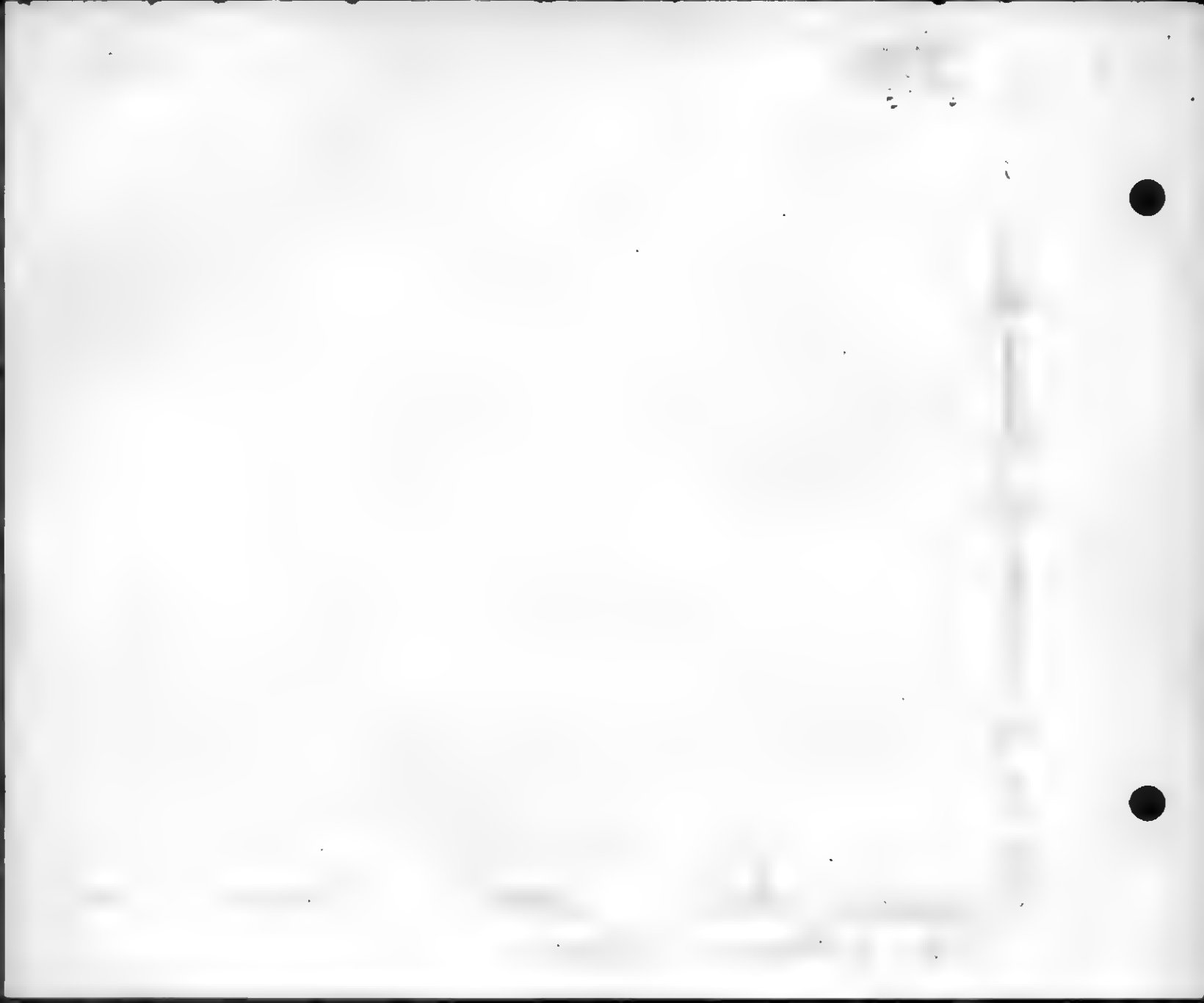
Released for cremation by Gregory Board on 11/16/66

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15175 CERTIFICATE OF DEATH 15173

Item 2 - Information from birth cert.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>24 HRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>56 GREATER BALTIMORE MEDICAL CENTER</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE Sykesville</u> d. STREET ADDRESS <u>Box 233, Sykesville, Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY GIRL</u>		First Middle Last <u>BOGGS</u>		4. DATE OF DEATH <u>NOV. 15 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/66</u>		9. AGE (In years last birthday) <u>24</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>H.L. Boggs.</u>		14. MOTHER'S MAIDEN NAME <u>Doris Ann Boggs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>PARENTS</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY PARALYSIS</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>IMMATURITY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (he) (this hospital) attended the deceased from <u>Oct. 30, 1966</u> to <u>Nov. 1, 1966</u> , that (he) (we) last saw the deceased alive on <u>Nov. 15 1966</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Margaret E. Lang, MD</u>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>MARGARET E. LANG MD</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>11/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GRIMC</u>			
23d. LOCATION (City, town or county) (State) <u>Towson 4, Md.</u>							
24. FUNERAL DIRECTOR <u>John E. Adams</u>		ADDRESS <u>GRIMC</u>		25a. REC'D BY REGISTRAR <u>gcharles judge</u>			
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 14 1966</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

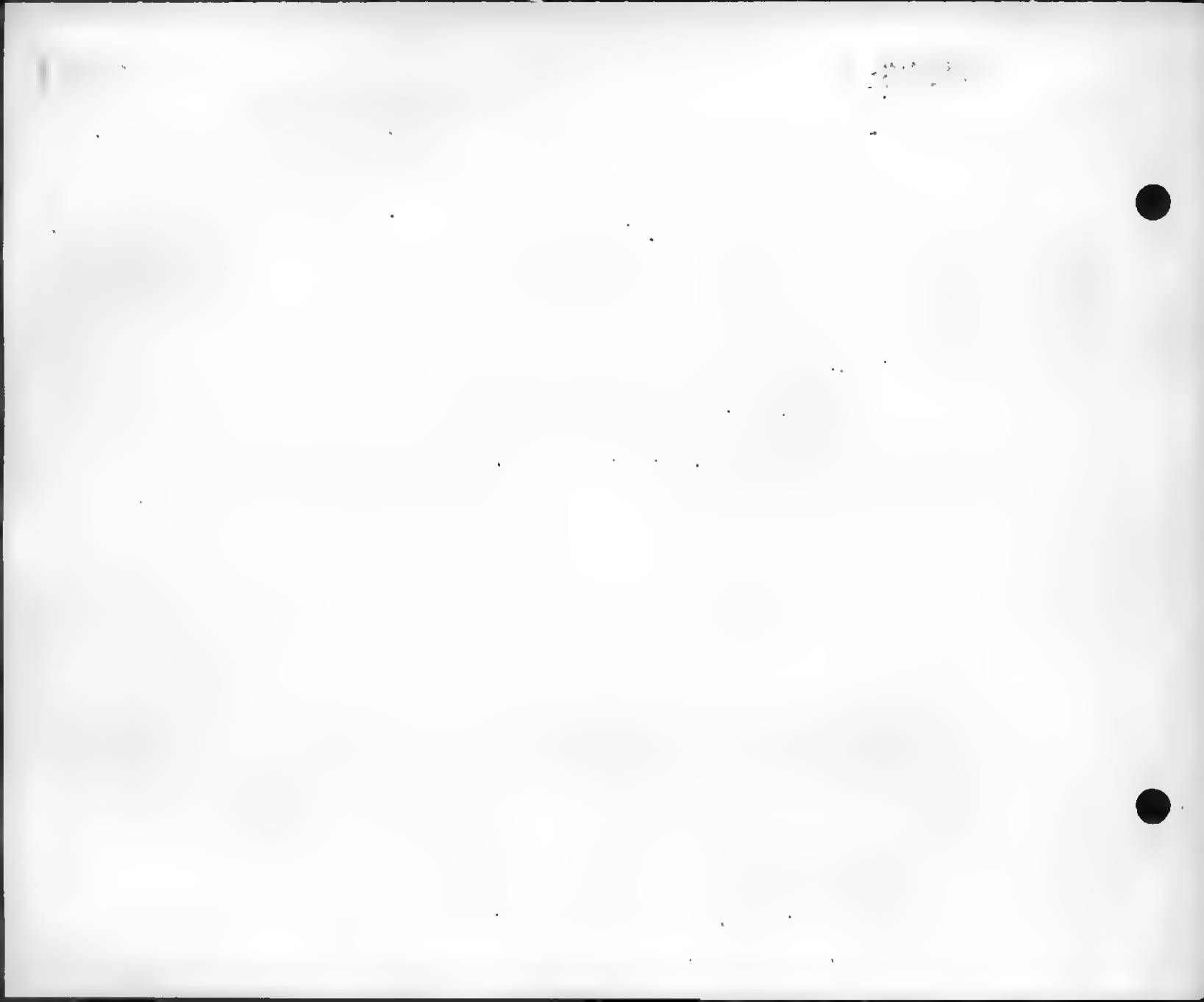
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15176

CERTIFICATE OF DEATH

15174

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
f. STREET ADDRESS <u>9 Croftley Road</u>		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Bognanni</u>		4 DATE OF DEATH Month Day Year <u>November 4, 1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 29, 1889</u>
9 AGE (In years last birthday) <u>77</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Joseph Colaianni</u>		14. MOTHER'S MAIDEN NAME <u>Carmela Petralia</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>215-07-0037</u>	
17. INFORMANT <u>Mr. John P. Bognanni, 5927 Hyleshire Rd.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO <u>diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>4 Nov</u> , 19 <u>66</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>5 Nov</u> 19 <u>66</u> , and that death occurred at <u>6 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William F. Fritz</u>		22b. DATE SIGNED <u>11/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM F. FRITZ</u>		22d ADDRESS <u>2 W. UNIVERSITY PARKWAY - 21214</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/8/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

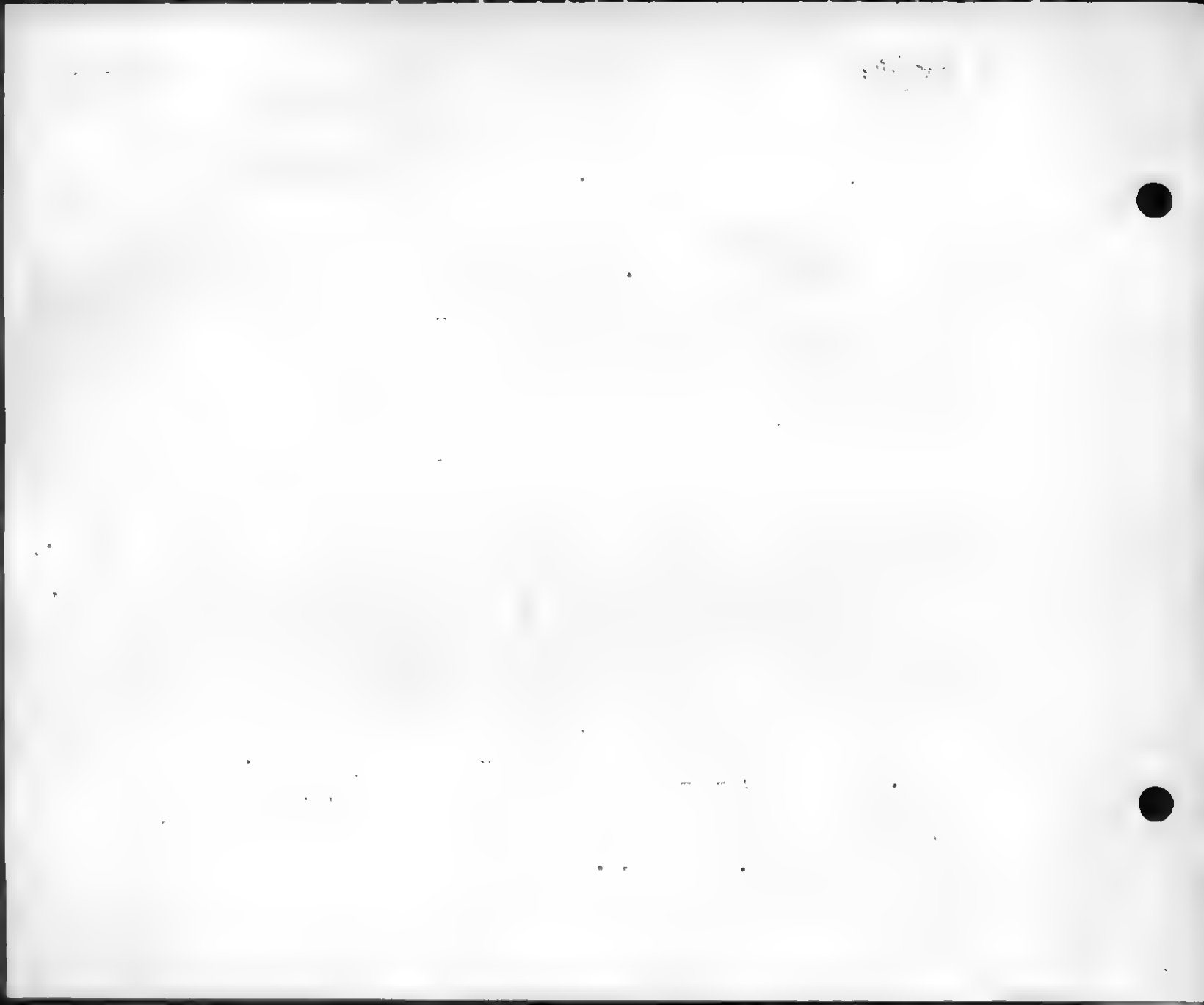
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2c & d Film 21383 12/15/66 pc

15177

CERTIFICATE OF DEATH

15175

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford, Harford Co., Maryland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>Trade Avenue</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAURIE</b> Middle <b>M.</b> Last <b>BOYD</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-1890</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pen Work</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hayre de Grace</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE HENRY BOYD</b>				14. MOTHER'S MAIDEN NAME <b>CALLIE AILENDER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>RECORDS: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular heart disease</b> (c) <b>Arteriosclerosis - generalized</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>3 yrs.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-20-63</b> , 19 to <b>Nov. 24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-24-</b> 19 <b>66</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Harford Harford Co. Md</b>	
24. FUNERAL DIRECTOR <i>Anthony J. Young</i>				25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15178

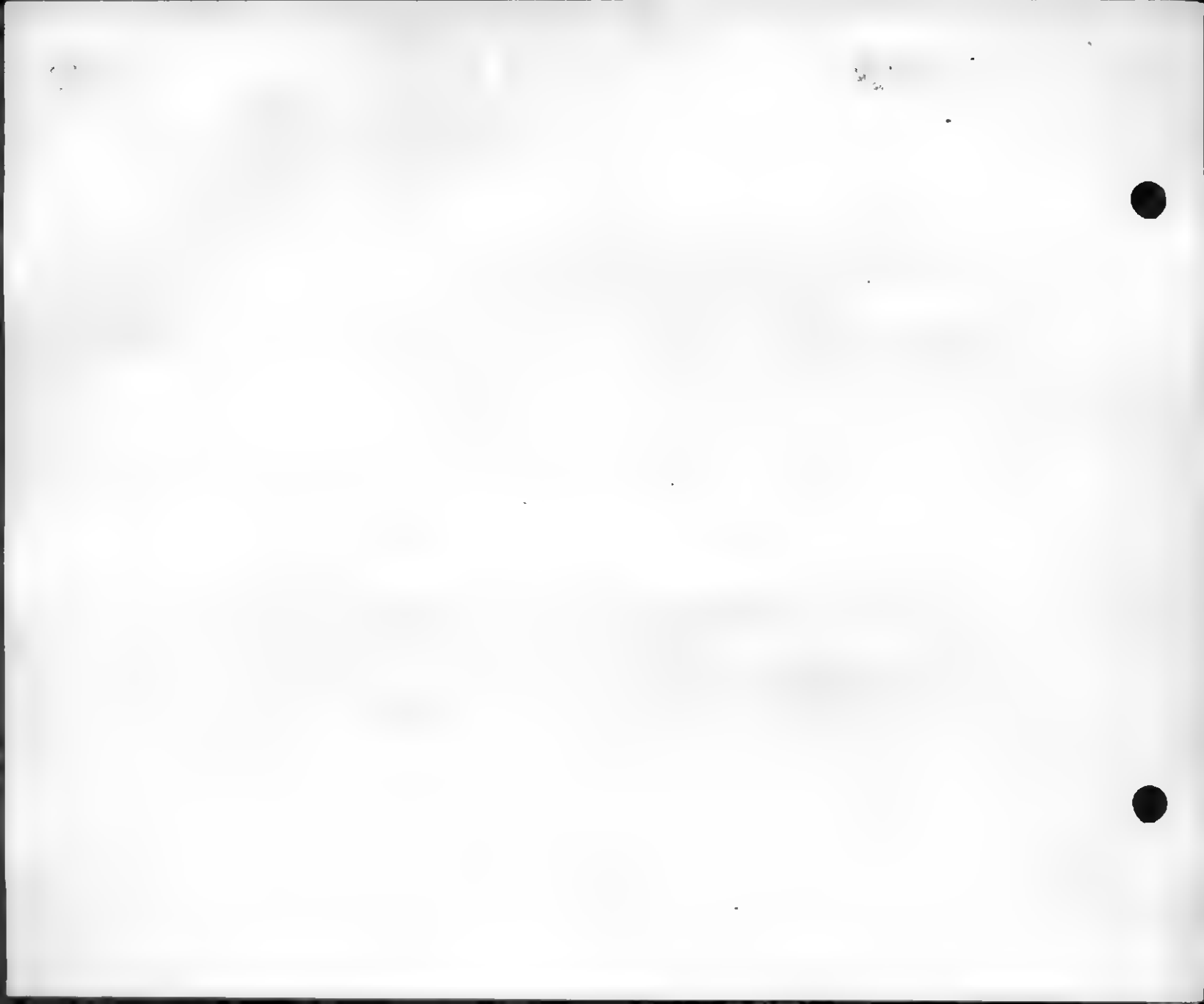
## CERTIFICATE OF DEATH

15176

1 PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>210 HILTON AVE</b>		d. STREET ADDRESS <b>210 HILTON AVE</b>	
3 NAME OF DECEASED (Type or print) <b>JOSEPH HARRY BRAND</b>		4 DATE OF DEATH <b>NOV 23 1966</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/5/20</b>
9 AGE (In years last birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CO. MD</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>MD</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>T. HARRY BRAND SR.</b>		14. MOTHER'S MAIDEN NAME <b>MINNA HARTUNG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>DOROTHY BRAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary artery disease with myocardial infarction</b> DUE TO (b) <b>myocardial infarction</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 18</b> , 1966, to <b>Nov 23</b> , 1966, that (I) (we) last saw the deceased alive on <b>18 Nov</b> 1966, and that death occurred at <b>6:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John Nesbitt Jr.</b>		22b. DATE SIGNED <b>11-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A NESBITT JR</b>		22d. ADDRESS <b>1207 Frederick Pl, Baltimore Md 21201</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/26/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO CO. MD</b>
24. FUNERAL DIRECTOR <b>E. S. MACNABB</b>		25a. REC'D BY REGISTRAR <b>NOV 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15179

## CERTIFICATE OF DEATH

15177

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALETHORPE</b>			c LENGTH OF STAY IN 1b <b>HALETHORPE</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALETHORPE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1219 FRANCIS AVENUE, 21227</b>				d STREET ADDRESS <b>1219 FRANCIS AVENUE, 21227</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>BESSIE F. RING BRANSKY</b>				4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1966</b>					
5 SEX <b>FEMALE</b>		6 COLOR OR RACE <b>WHITE</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>11-11-1881</b>		9. AGE (in years last birthday) <b>85</b> yrs.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID RING</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA ZIMMERMAN</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16 SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT Address <b>MR. ZIMMERMAN RING, 1250 FRANCIS AVENUE, #27</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>TXU1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis Generalized</b> DUE TO (c) <b>-----</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1957</b> to <b>Nov 16, 1966</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Sept 6, 1966</b> , and that death occurred at <b>5:05</b> M, from causes and on the date stated above.									
22a SIGNATURE <b>John C. Healy</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. HEALY</b>						22d. ADDRESS <b>1311 FRANCIS AVENUE, 21227</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-19-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>			23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24 FUNERAL DIRECTOR <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21227</b>						25a FILED BY REGISTRAR <b>NOV 21 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capers papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1171

1172

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and notify event within 72 hours after death.

VR A15ME (5)  
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

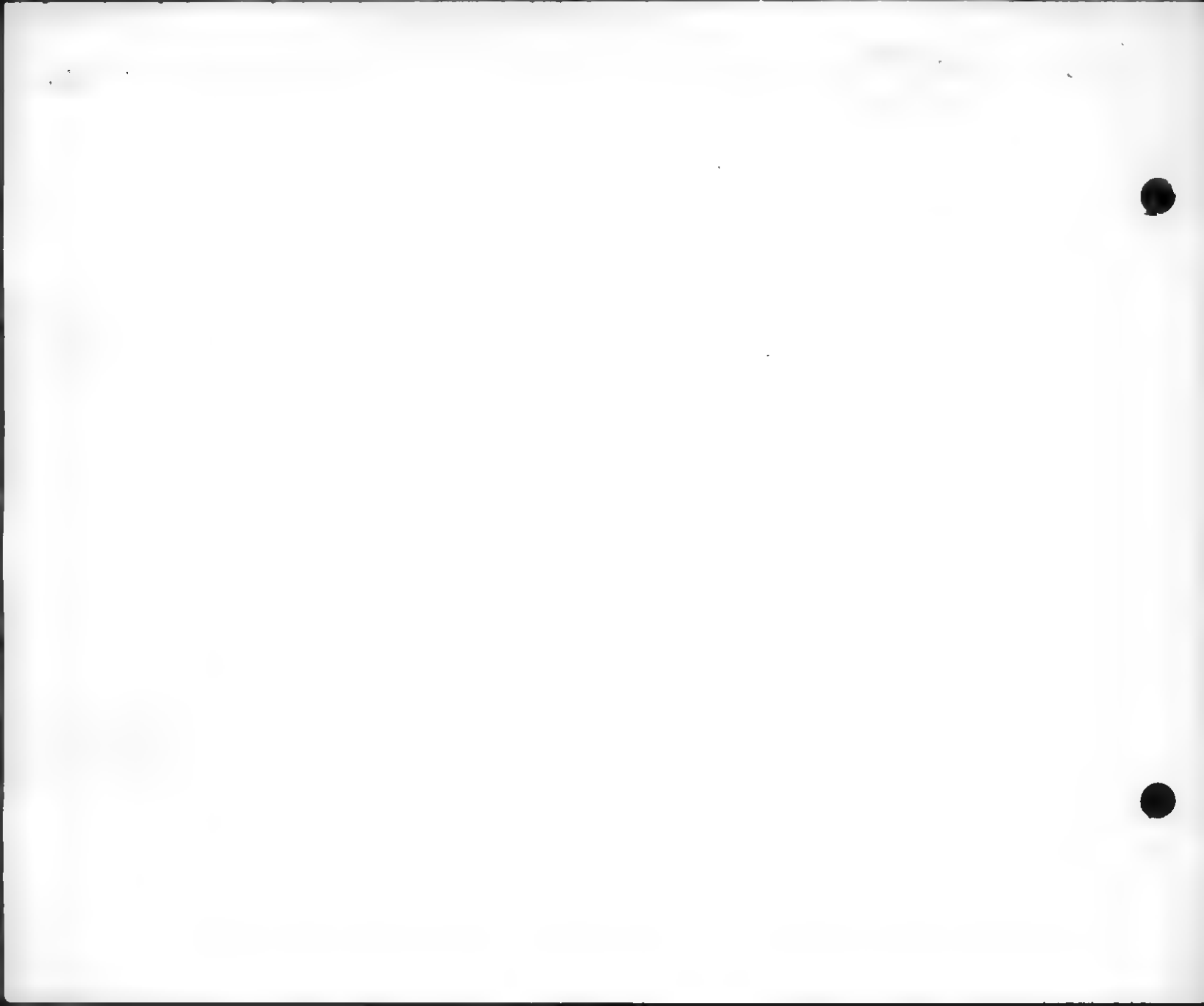
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15180

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15178

1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admssion) a. STATE <u>Ind.</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Pikesville</u>		d. STREET ADDRESS <u>544 Woodside Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>544 Woodside Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First Middle Last				4. DATE OF DEATH <u>NOV. 5 19 66</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 11, 1885</u>	9. AGE (in years last birthday) <u>80</u> yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>aud. Prod.</u>		11. BIRTHPLACE (State or foreign country) <u>Balt. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon Bransky</u>				14. MOTHER'S MAIDEN NAME <u>Bella</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOC. A. SECURITY NO. <u>705-05-3024</u>		17. INFORMANT Address <u>Lillian Bransky - Same.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Angina</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>2 yrs</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <u>none.</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month Day, Year Hour am pm <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>none.</u>		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u> EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED <u>11-5-66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Sol Leunow &amp; Sons Inc - 6010 Rust Road</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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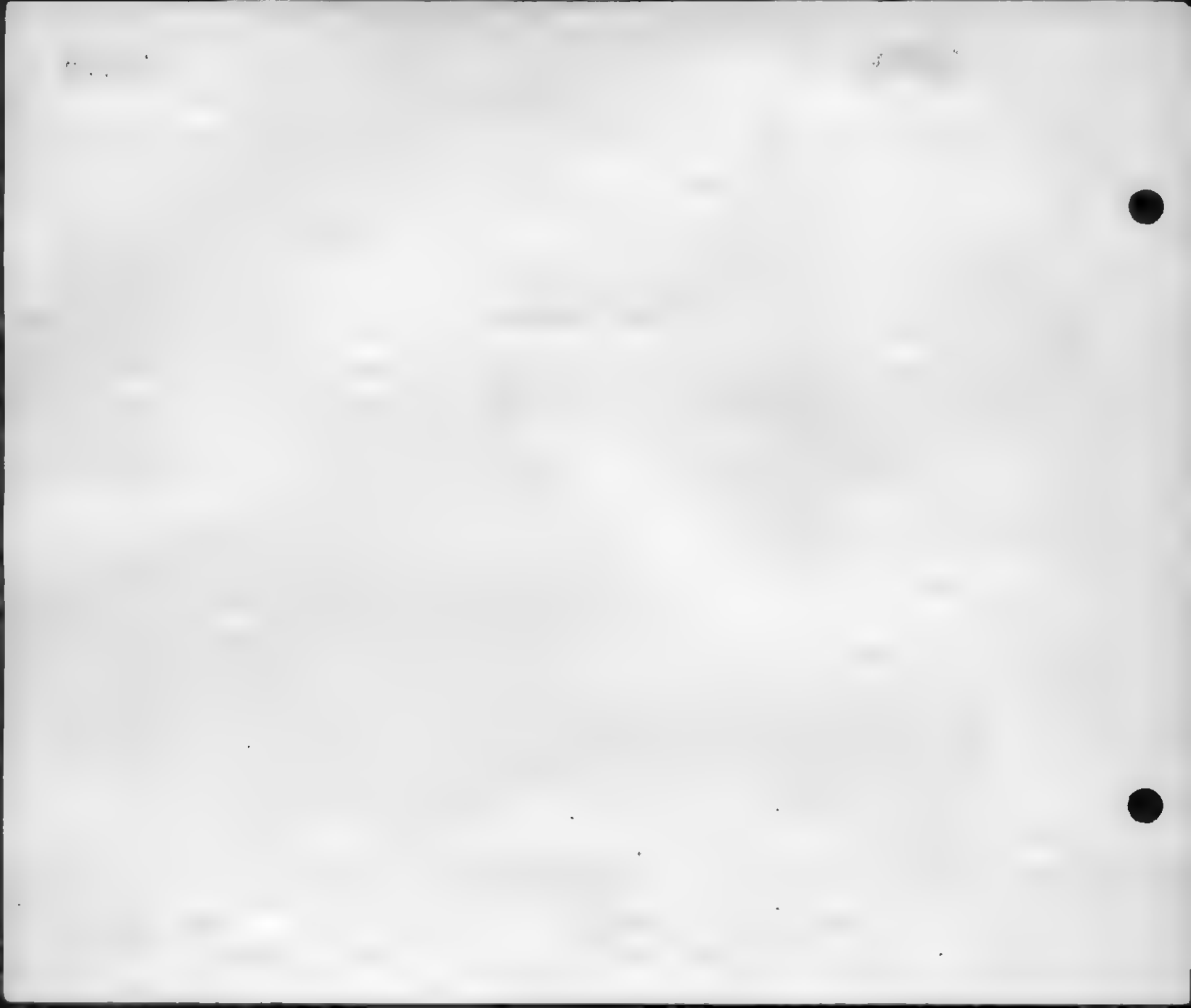
**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15181

15179

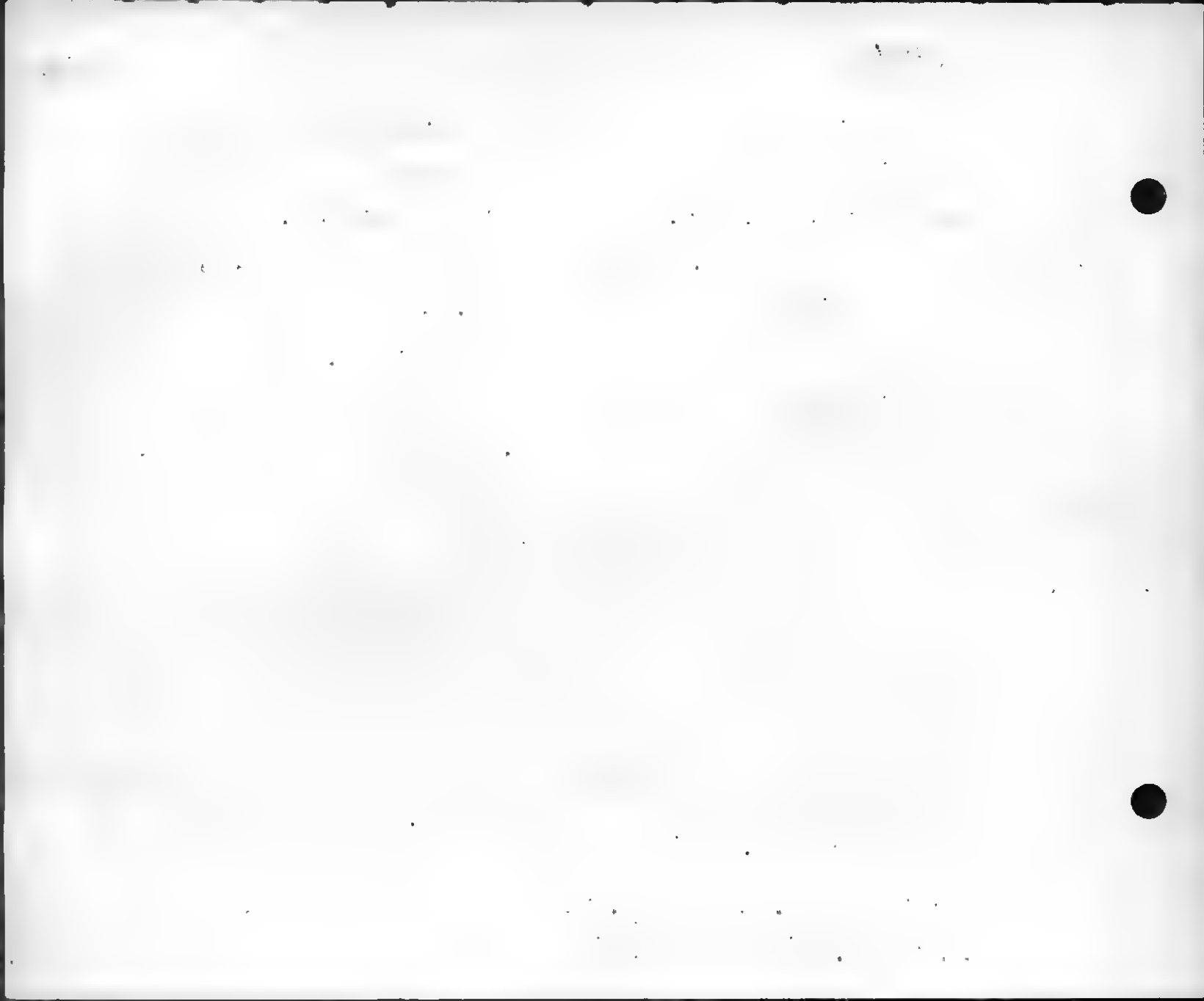
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> Baltimore		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) <b>a. STATE</b> Maryland		<b>b. COUNTY</b> Baltimore	
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Towson		<b>c. LENGTH OF STAY IN 1b</b> 10 yrs.		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Baltimore	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) Stella Maris Hospital		<b>d. STREET ADDRESS</b> 3401 Hamilton Avenue, 74		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last William Henry Cook		<b>4. DATE OF DEATH</b> Year Month Day 1966 11 17			
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> Year Month Day 1936 10 10		<b>9. AGE</b> (In years last birthday) 30 yrs.		<b>IF UNDER 1 YEAR</b> Months Days 11 17	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) housekeeper		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Baltimore, Md.	
<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.		<b>13. FATHER'S NAME</b> Charles Emil Cook		<b>14. MOTHER'S MAIDEN NAME</b> Mary Ann Cook	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) no		<b>16. SOCIAL SECURITY NO.</b> 213-26-0277		<b>17. INFORMANT</b> self	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> ASCVD <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Mellitus (c) Pneumonia		<b>INTERVAL BETWEEN ONSET AND DEATH</b> Days Hours Minutes 1 17 00			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> ..... <b>19</b> ..... <b>to</b> ..... <b>19</b> ..... <b>that (I) (we) last saw the deceased alive on</b> ..... <b>19</b> ..... <b>and that death occurred at</b> ..... <b>M.</b> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> (Type or print) William H. Cook		<b>22b. DATE SIGNED</b> Year Month Day 1966 11 17		<b>22c. PHYSICIAN'S NAME</b> (Type) Wm. Cook-Brooks	
<b>22d. ADDRESS</b> Towson, Md.		<b>22e. REC'D BY REGISTRAR</b> <b>22f. REGISTRAR'S SIGNATURE</b> Charles Judge			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE THEREOF</b> Nov. 17, 66		<b>23c. NAME OF CEMETERY OR CREMATORY</b> New Cathedral	
<b>23d. LOCATION</b> (City, town or county) Baltimore,		<b>(State)</b> Baltimore, Md.			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
15182										
15180										
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN ID <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House in Pines, Fusting Ave.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>7921 Holabird Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LENA I. BROWN</b> First Middle Last					4. DATE OF DEATH <b>Nov. 11, 1966</b> Month Day Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 21, 1888</b>		9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Specht</b>					14. MOTHER'S MAIDEN NAME <b>Mary Aurelia</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Edna Rugemer, 7149 Holabird Ave. Dundalk</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8-8-</b> , 19 <b>66</b> , to <b>11-11-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-9</b> 19 <b>66</b> , and that death occurred at <b>6:00</b> M, from the causes and on the date stated above.										
22a. SIGNATURE <b>Wilmer K. Ballager</b>					22b. DATE SIGNED <b>11-11-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Ballager</b>			
22d. ADDRESS <b>6209 Frederick Ave. Baltimore, 28, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		23d. LOCATION (City, town or county) (State) <b>Alpha, Md</b>				
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>					25a. REC'D BY REGISTRAR <b>Nov 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

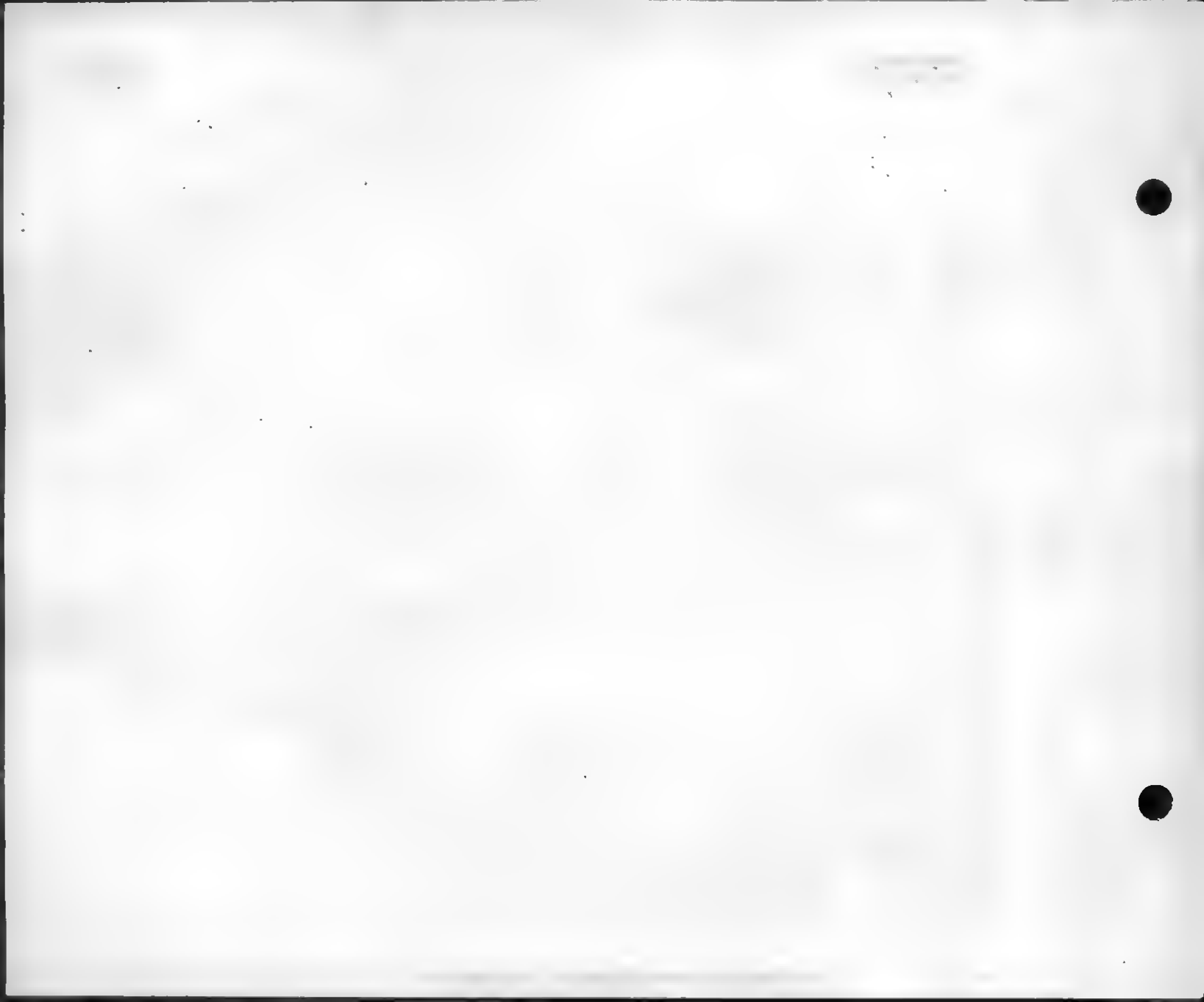
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15183

CERTIFICATE OF DEATH

15181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDOLPH TOWN</u>		c. LENGTH OF STAY IN TB <u>2 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		21208 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. Co. Gen. Hosp</u>		d. STREET ADDRESS <u>707 Templecliff Rd</u>	
3. NAME OF DECEASED (Type or print) <u>WEC Alfred</u> First Middle Last		4. DATE OF DEATH <u>11-7-</u> 19 <u>66</u> Month Day Year	
5. SEX <u>M</u>	6. CO. OR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-16</u> 4? yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life event retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Manufacturing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo Albert Buckley</u>		14. MOTHER'S MAIDEN NAME <u>MARIE OWENS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal cancer</u> DUE TO (b) <u>portal cirrhosis with portal hypertension</u> DUE TO (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-24-1966</u> , to <u>11-7-1966</u> , that (I) (we) lost saw the deceased alive on <u>11-7-1966</u> , and that death occurred at <u>12:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Jagan</u> M.D.		22b. DATE SIGNED <u>11/7/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>BALTO. County Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Nov. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY BALTIMORE MD.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Newell Funeral Home, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1966</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15184					15182				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>BALTIMORE</b>					a. STATE <b>MD.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE TOWSON</b>					b. COUNTY <b>BALTO.</b>				
c. LENGTH OF STAY IN 1b <b>Life</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER</b>					d. STREET ADDRESS <b>256 Rodgers Forge Rd</b>				
3. NAME OF DECEASED (Type or print)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
First <b>Elizabeth</b> Middle <b>E.</b> Last <b>CALLIS</b>					f. DATE OF DEATH				
5. SEX <b>F</b>					8. DATE OF BIRTH <b>4/22/89</b>				
6. COLOR OR RACE <b>CAU.</b>					9. AGE (In years last birthday) <b>77</b> yrs.				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. HOMEMAKER</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
13. FATHER'S NAME <b>William Eisenhardt</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Patient's</b>					Address <b>CHART</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>Cardiac Failure</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <b>myocardial infarction</b>									
(c) <b>Arteriosclerotic Cardio Vascular Disease</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. <b>19</b> p.m.									
20d. INJURY OCCURRED									
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>11-4</b> , 19 <b>66</b> , to <b>11-19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-19</b> , 19 <b>66</b> , and that death occurred at <b>3:45 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Ram K. Chhillar</b>									
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <b>RAM K. CHHILLAR</b>									
22d. ADDRESS <b>GREATER BALTO MED. CENTER BALTIMORE MD.</b>									
22e. DATE SIGNED <b>11-19-66</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
23b. DATE THEREOF <b>11/22/1966</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>									
23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>									
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Maryland</b>									
25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>									
25b. REGISTRAR'S SIGNATURE <b>Charles O.</b>									

SECRET

SECRET

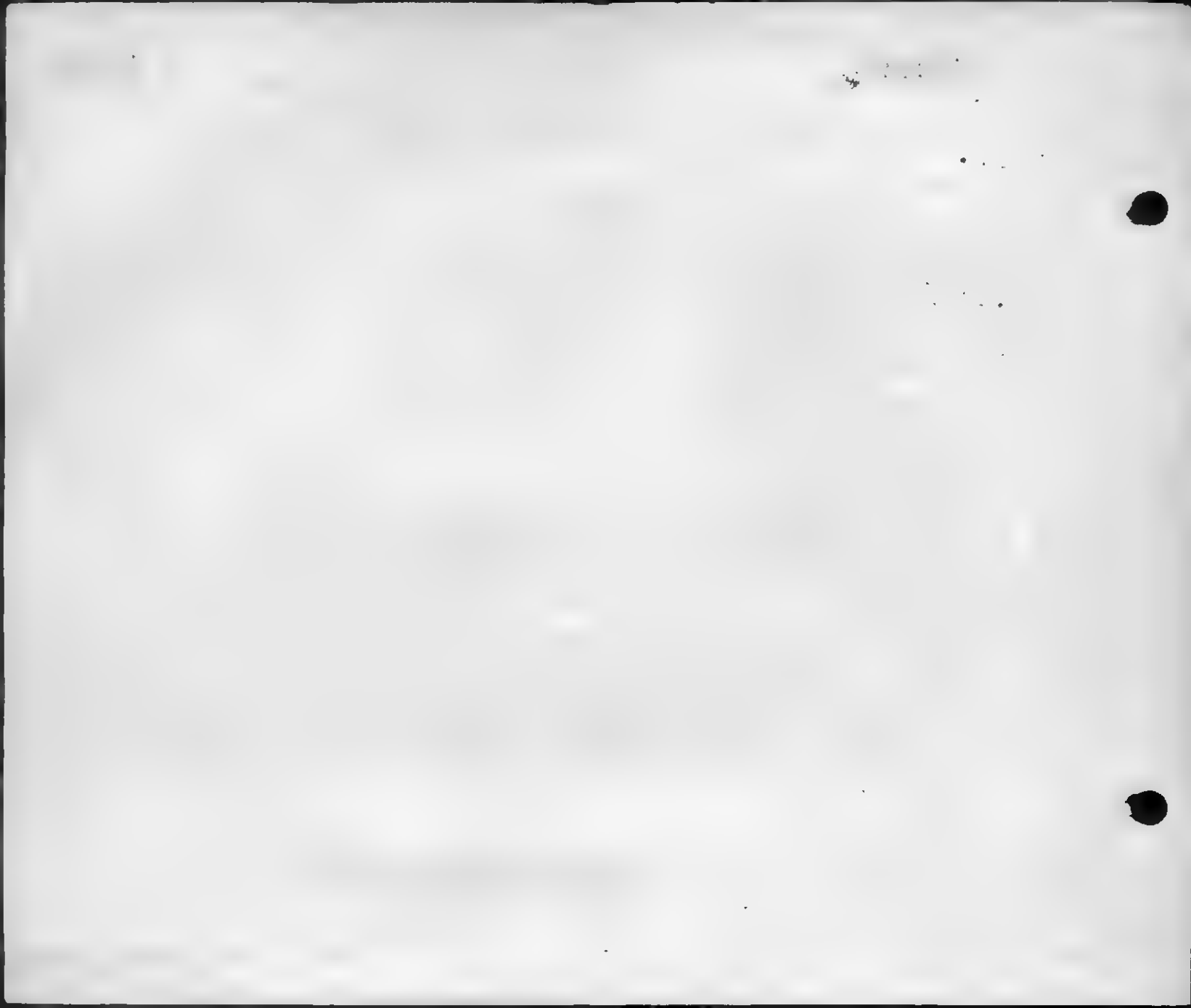
SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15185						15183					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Baltimore			a. STATE			b. COUNTY		
			MARYLAND			Maryland			Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN It			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Dundalk						Dundalk			212 Cleveland Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						212 Cleveland Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Charlotte L. Campbell						November 23,			19 66		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White				June. 26, 1893		73 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
At home								Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
James Campbell				Hildgiess				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No								Howard J. Campbell 109 S. Broadway			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Right base</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 21, 1966</u> to <u>Nov. 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 23, 1966</u> , and that death occurred at <u>12:30 P.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Benigno R. Lazaro</u>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Benigno R. Lazaro, M.D.				22d. ADDRESS 59 Dundalk Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			11/26/66			St. Matthew's Cemetery			Baltimore, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Ullrich Funeral Home Dundalk, Md.						DATE NOV 28 1966 <u>Charles Judge</u>					



1

2

15186

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 8 Film G383 12/9/66 mh

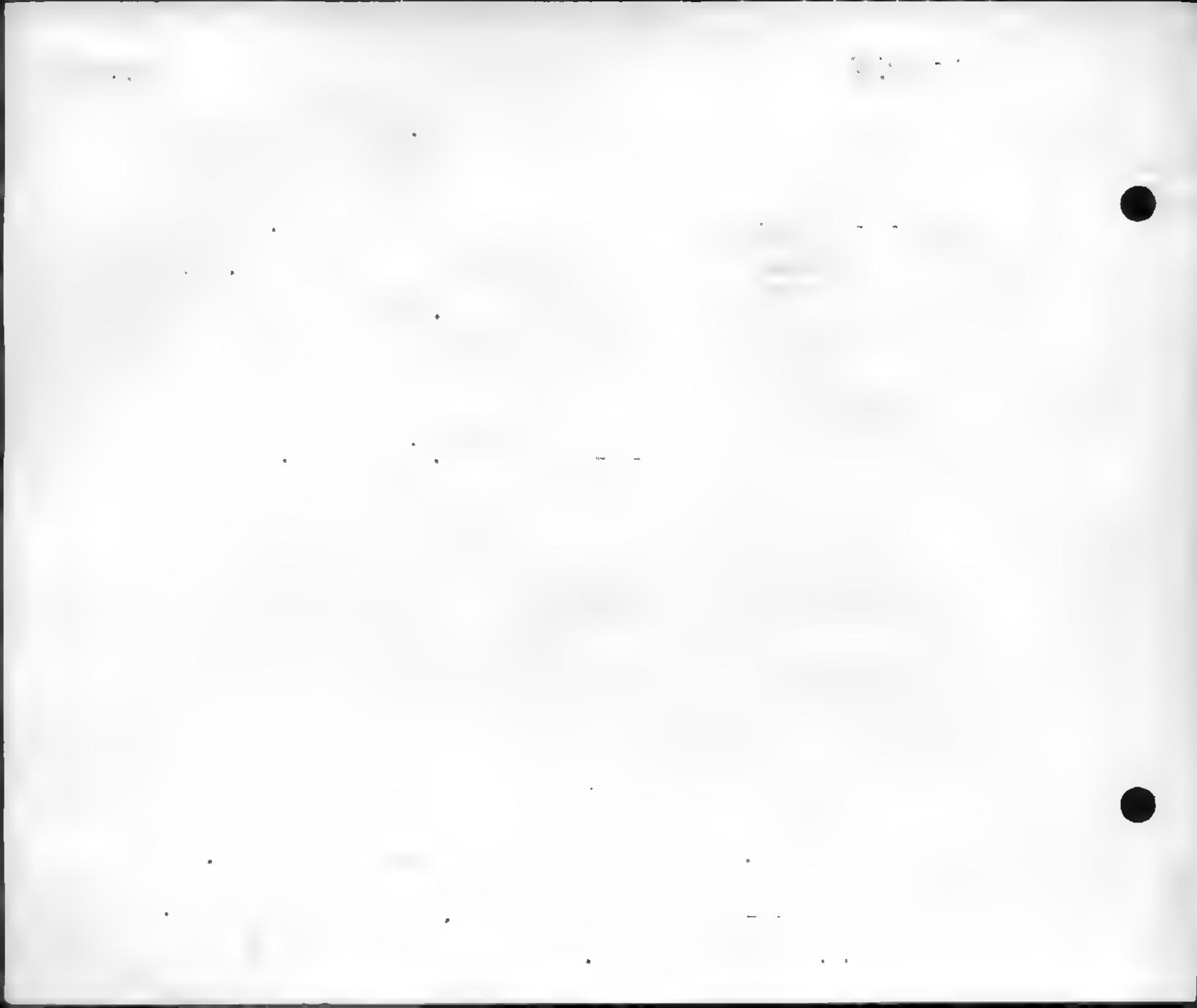
CERTIFICATE OF DEATH

15184

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House-in-Pines Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4606 Manordene Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Campbell</b> First Middle Last 4. DATE OF DEATH <b>Nov. 29, 1966</b> Month Day Year		5. SEX <b>F</b> 6. COLOR OR RACE <b>Wh</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 14/79</b> 9. AGE (In years lost birthday) <b>87</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Campbell</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>212-01-2331</b>	
17. INFORMANT <b>Helen M. Engel</b> <b>100 S. Augusta Ave.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis &amp; Thrombosis</b> DUE TO <b>C Rt. Hemisphere</b> (and if any, which gave rise to immediate cause (a), stating the underlying cause lost) DUE TO <b>Arteriosclerotic Cardio Vascular Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 17, 1966</b> to <b>Nov 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 28, 1966</b> , and that death occurred at <b>12:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Harry L. Knipp</b> 22c. PHYSICIAN'S NAME (Type) <b>Harry L. Knipp</b>		22b. DATE SIGNED <b>11-30-66</b> 22d. ADDRESS <b>4116 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-2-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1966</b> 25b. REGISTRAR'S SIGNATURE <b>W. J. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15187

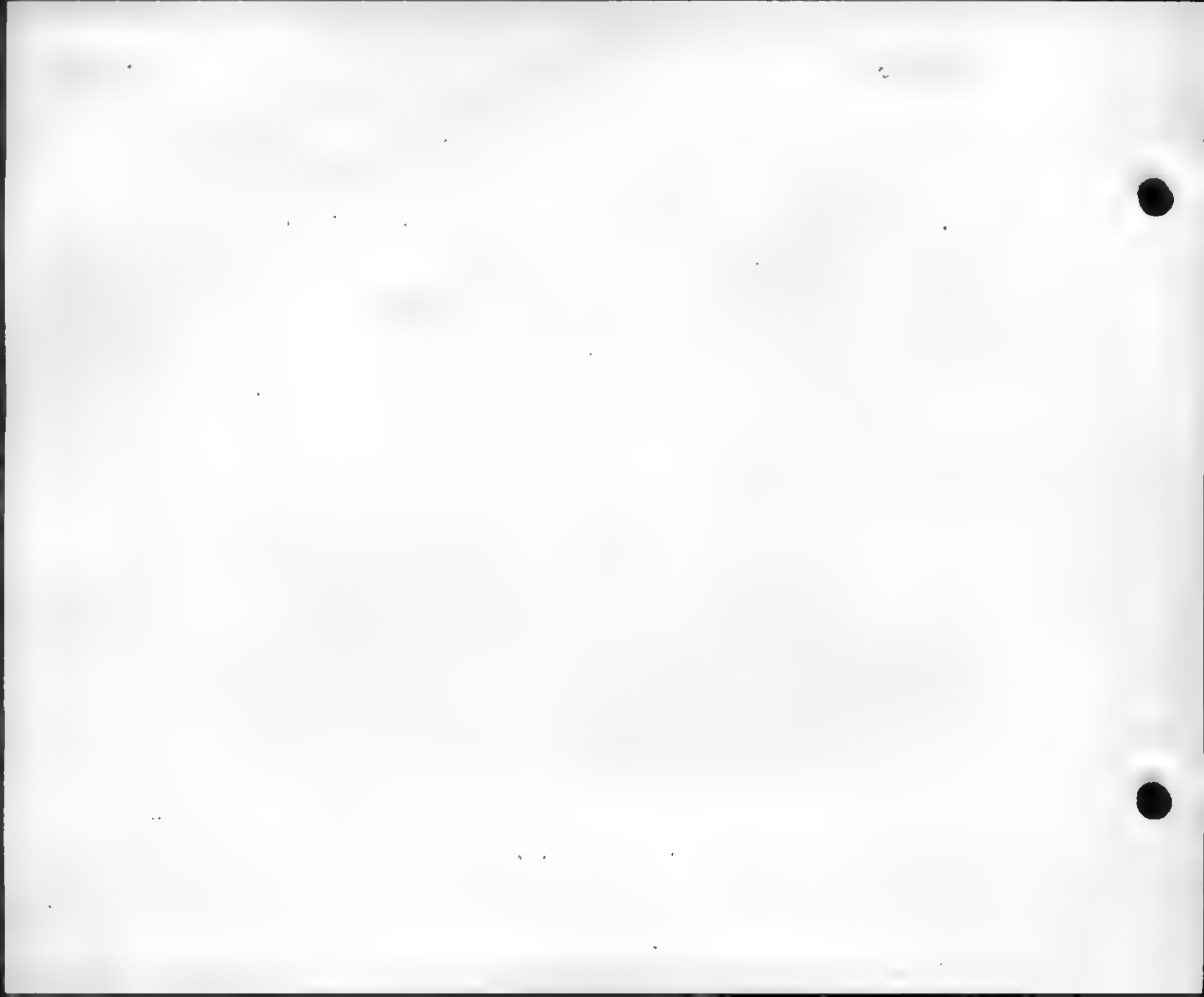
CERTIFICATE OF DEATH

15185

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c LENGTH OF STAY IN 1b <b>LIFE</b> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore 21234</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b> d STREET ADDRESS <b>3117 E. Joppa Rd.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>S. Mildred</b> First Middle Last <b>CARNEY</b>		4 DATE OF DEATH Month Day Year <b>November 21, 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-12-1882</b>
9 AGE (In years last birthday) <b>84</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b KIND OF BUSINESS OR INDUSTRY <b>in School</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>A</b>	
13 FATHER'S NAME <b>Thomas Carney</b>		14 MOTHER'S MAIDEN NAME <b>Mary Mc Demott</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>HOSPITAL RECORDS</b>	
17 INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> DUE TO (b) <b>massive bilateral pleural effusion and atelectasis</b> DUE TO (c) <b>(pleural effusion was produced by a malignant process)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinomatosis of lungs; Metastatic from breast</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>11/15/</b> , 19 <b>66</b> , to <b>11/21/</b> , 1966, that <b>A</b> (we) lost saw the deceased alive on <b>11/21/</b> , 19 <b>66</b> , and that death occurred <b>11:40 P.M.</b> , from causes on and on the date stated above.			
22a SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b DATE SIGNED <b>11-21-66</b>	
22c PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d ADDRESS <b>7620 York Rd., Baltimore, Md, 21204</b>	
23a BURIAL, CREMATION REMOVAL (Specify) <b>CREMATION</b>	23b DATE THEREOF <b>11-25-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d LOCATION (City or town) (County) (State) <b>Baltimore Md</b>
24 FUNERAL DIRECTOR <b>Chas. F. Evans + Son</b>		25a REC'D BY REGISTRAR <b>NOV 25 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

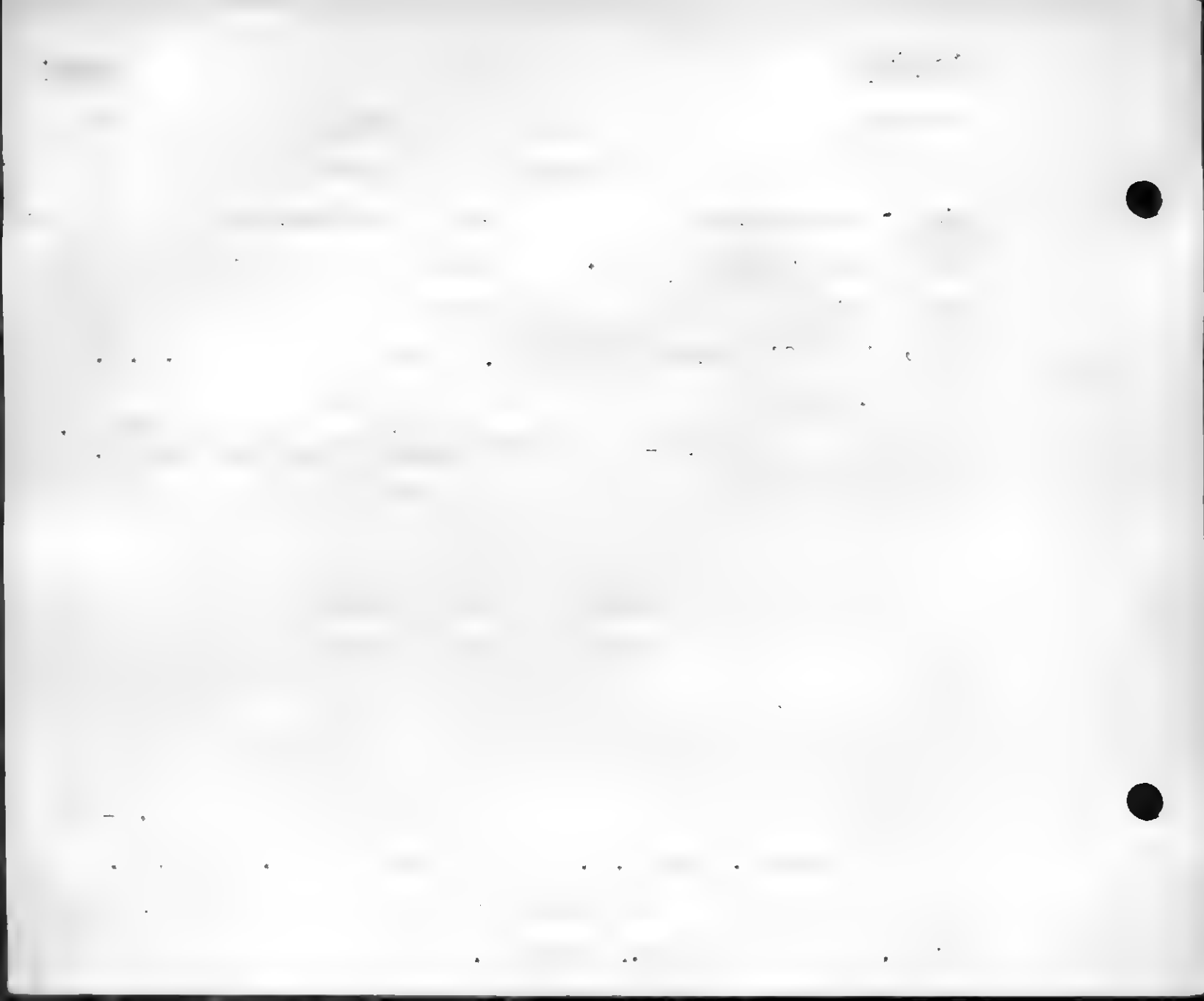
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<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>15188</b></p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>15186</b></p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Baltimore</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b></p> <p>c. LENGTH OF STAY IN 1b <b>38 Years</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>714 Old North Point Road</b></p>					<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b></p> <p>b. COUNTY <b>Baltimore</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b></p> <p>d. STREET ADDRESS <b>714 Old North Point Road</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>Samuel</b> Middle <b>C.</b> Last <b>Carson</b></p>			<p>4. DATE OF DEATH</p> <p>Month <b>November</b> Day <b>30</b> Year <b>1966</b></p>			<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR RACE <b>White</b></p>	
<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			<p>8. DATE OF BIRTH</p> <p><b>10/29/98</b></p>			<p>9. AGE (in years last birthday) <b>68</b> yrs.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Supervisor</b></p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY <b>Smelting &amp; American Refining Co.</b></p>			<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Maryland</b></p>			<p>12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b></p>			
<p>13. FATHER'S NAME <b>George W. Carson</b></p>					<p>14. MOTHER'S MAIDEN NAME <b>Mary Sittler</b></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p>			<p>16. SOCIAL SECURITY NO. <b>212-10-1591</b></p>		<p>17. INFORMANT (Wife) <b>Nellie Carson</b> Address <b>Dundalk, Md.</b></p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b></p> <p>DU TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>None</b></p> <p>DU TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>									<p>INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b></p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>									<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>									<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <b>19</b></p>
<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>									<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>
<p>20f. (City or town) (County) (State)</p>									<p>21. I certify that (I) (this hospital) attended the deceased from <b>Oct - 1966</b>, to <b>Nov. 30, 1966</b>, that (I) (we) last saw the deceased alive on <b>Nov. 23, 1966</b>, and that death occurred at <b>10:40 A.M.</b> from the causes and on the date stated above.</p>
<p>22a. SIGNATURE <b>M B Davis</b></p>									<p>22b. DATE SIGNED <b>Dec. 1-1966</b></p>
<p>22c. PHYSICIAN'S NAME (Type) <b>Melvin B. Davis M. D.</b></p>									<p>22d. ADDRESS <b>6800 Morningside Rd. Dundalk, Md.</b></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>			<p>23b. DATE THEREOF <b>12/3/66</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b></p>			<p>23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b></p>	
<p>24. FUNERAL DIRECTOR</p> <p>ADDRESS <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b></p>					<p>25a. REC'D BY REGISTRAR <b>DEC 2 1966</b></p> <p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>				



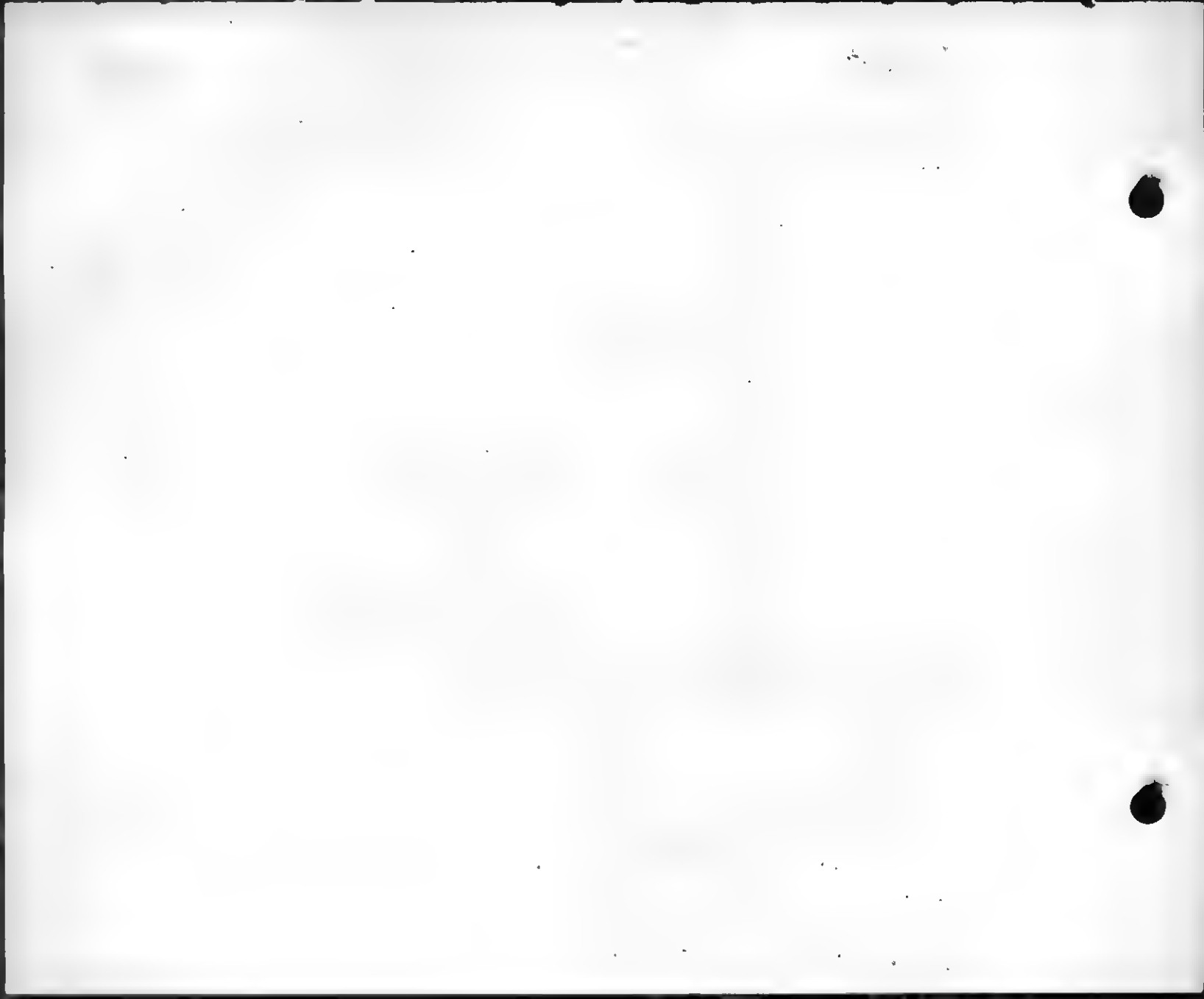


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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15189		15187									
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN ID <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HALESTOWN</b> d. STREET ADDRESS <b>161 N. JONATHAN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ANNIE</b> First Middle Last <b>CARTER</b>						4. DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>1966</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/10/94</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>ROB BOSS</b>						14. MOTHER'S MAIDEN NAME <b>KATE COXSON</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-02-6862</b>		17. INFORMANT <b>Records, Mt. Wilson State Hospital</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHOLERA and BRONCHO-PNEUMONIA</b> 4711 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>0821</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Tuberculosis. Generalized arteriosclerosis.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (if this hospital) attended the deceased from <b>8/15</b> , 19 <b>66</b> , to <b>11/22</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>11/22</b> , 19 <b>66</b> , and that death occurred at <b>5</b> PM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Wm. Newcomer</b>						22b. DATE SIGNED <b>11/23/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>						22d. ADDRESS <b>Mount Wilson, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Milton Valley Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Berryville, Virginia</b>		
24. FUNERAL DIRECTOR <b>John H. Enders Funeral Home</b>						25a. REC'D BY REGISTRAR <b>NOV 28 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION



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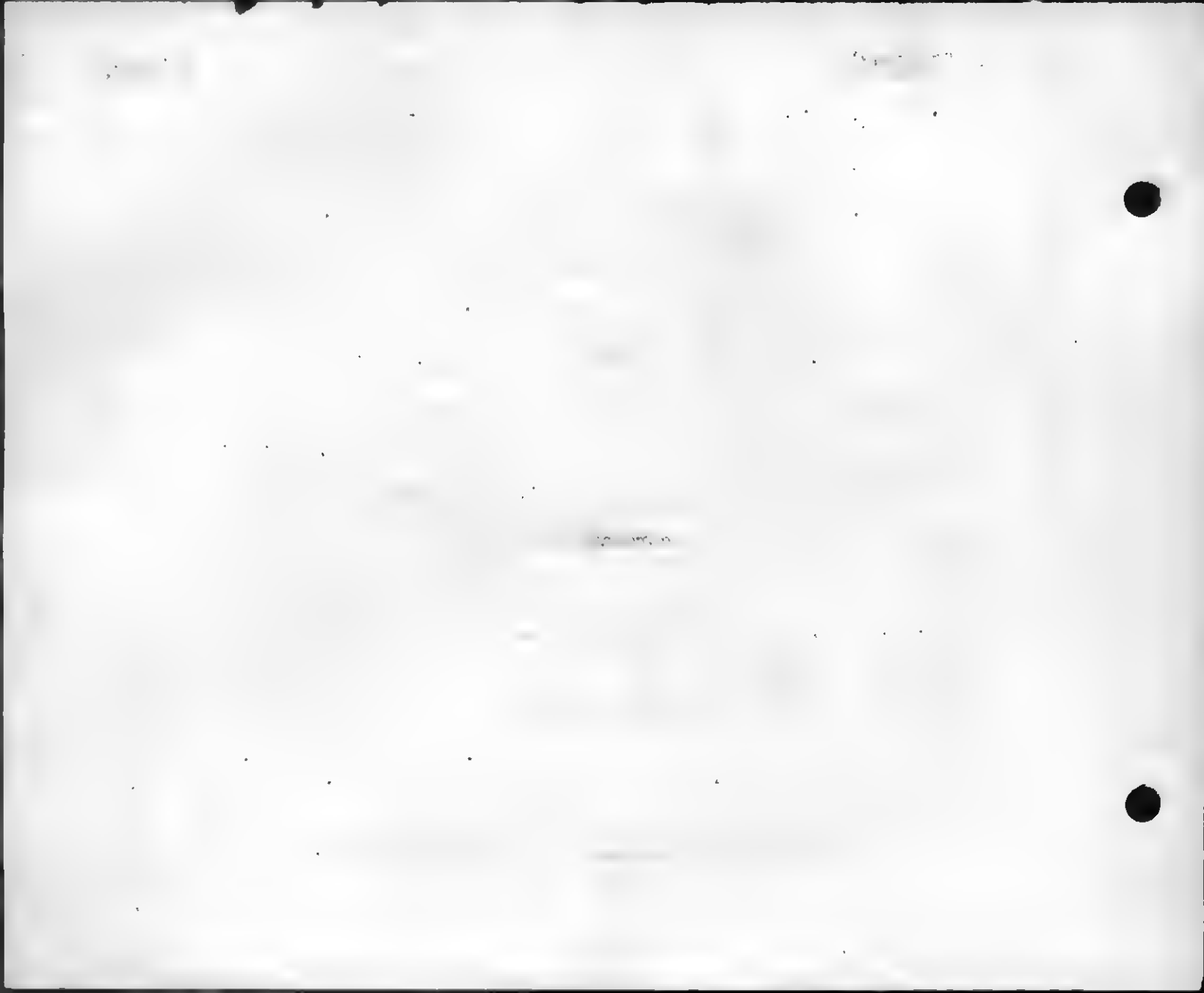
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15190

15188

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b> d. STREET ADDRESS <b>5230 York Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>First Elmer Middle Joshua Last Carter</b>		4. DATE OF DEATH <b>November 8 19 66</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1 1889</b>		9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Auctioneer--(fruit)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>				11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Franklin Carter</b>				14. MOTHER'S MAIDEN NAME <b>Laura Evans</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>same</b>			
17. INFORMANT <b>Mrs Florence P. Carter</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>coronary thrombosis.</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that <b>X</b> (this hospital) attended the deceased from <b>Nov. 6</b> , 19 <b>66</b> , to <b>Nov. 8</b> , 19 <b>66</b> , that <b>we</b> last saw the deceased alive on <b>Nov. 8</b> , 19 <b>66</b> , and that death occurred at <b>5PM</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>			
22b. DATE SIGNED <b>11/9/66</b>				22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>				22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>				22e. REC'D BY REGISTRAR <b>Nov 14 1966</b>			
22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>11-12-66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>			
23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>				24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>				25. ADDRESS <b>Nov 14 1966</b>				26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



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1

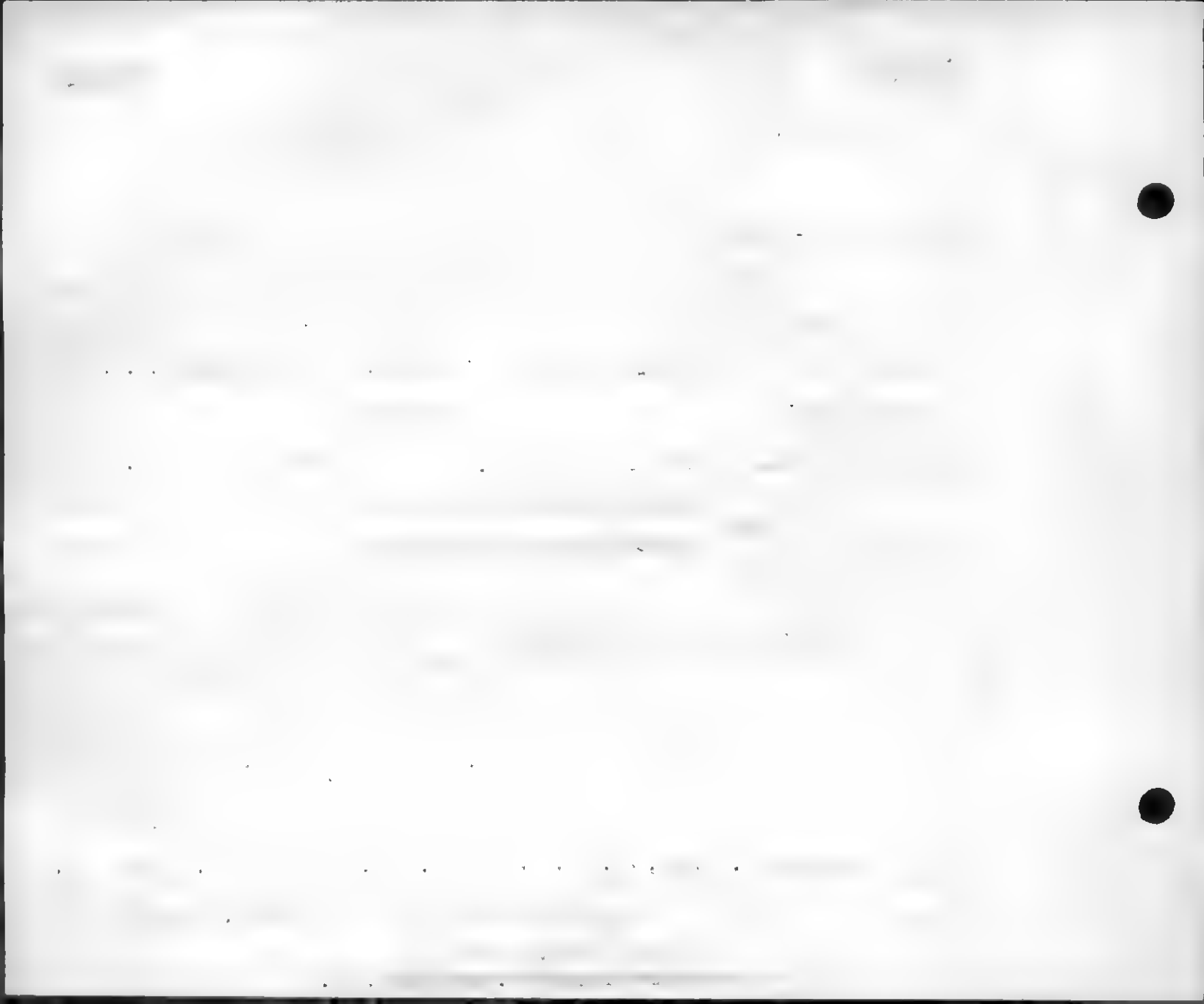
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 23b Film G-35 11/2/66 mh

15191

CERTIFICATE OF DEATH

15189

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>16 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1846 WEST SARATOGA STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH CARTER</b>				4 DATE OF DEATH Month Day Year <b>November 28 19 66</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10 28 09</b>		9 AGE (n years last birthday) <b>57</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING FACTORY</b>		11 BIRTHPLACE (County & State, or foreign country) <b>NEWBERRY, SOUTH CAROLINA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY CARTER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA ROBINSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>249-12-97-19</b>		17. INFORMANT Address <b>CLIN. REC., VAH, FORT HOWARD, MARYLAND</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> <b>ADENOCARCINOMA LUNG, PRIMARY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV. 12</b> , 19 <b>66</b> , to <b>NOV. 28</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>NOV. 28</b> , 19 <b>66</b> , and that death occurred at <b>1:30</b> a.m., from causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence F. Awalt, Jr.</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>				22d. ADDRESS <b>VET. ADM. HOSPITAL, FT. HOWARD, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Sherry O. Wilson</i>				25a. REC'D BY REGISTRAR DATE <b>NOV 29 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. ADDRESS <b>WILSON FUNERAL HOME</b> <b>2004 Orleans St. Baltimore, Md.</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15192

## CERTIFICATE OF DEATH

15190

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalls Town</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore Co. General</u>		d. STREET ADDRESS <u>3610 Forest Grove Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>CASTLEMAN</u> Last <u>CASTLEMAN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1887</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> Hours <u>12</u> Mins. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Deceatur Osborne</u>		14. MOTHER'S MAIDEN NAME <u>Vienna Osborne</u> (Maiden name <u>Unknown</u> )	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>217-54-9994T</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 wks</u> <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis, atherosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> , 19 <u>66</u> , to <u>11-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>66</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Judge</u>		22b. DATE SIGNED <u>11/25/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-27-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Crofton, Calverton, Md.</u>
24. FUNERAL DIRECTOR <u>E. J. Ender</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and must be retained, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15193

CERTIFICATE OF DEATH

15191

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c LENGTH OF STAY IN 1b <b>21224</b> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d STREET ADDRESS <b>2532 E. Fayette St.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Florence M CHALMES</b>		4 DATE OF DEATH Month Day Year <b>November 12, 1966</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1899</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Mins. <b>12</b> 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Virginia Phila., Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaiah Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Katherine ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-07-0363</b>	
17. INFORMANT <b>Mr. William Nottingham</b>		Address <b>6123 Elinore Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic enterocolitis</b> DUE TO (b) <b>Peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/10/</b> , 19 <b>66</b> , to <b>11/12/</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/12/</b> , 19 <b>66</b> , and that death occurred at <b>11:55</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Govinda Rao</b>		22b. DATE SIGNED <b>11/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Govinda Rao, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		25a. READ BY REGISTRAR DATE <b>NOV 16 1966</b>	
24. FUNERAL DIRECTOR <b>John A. Moran Inc, 2000 E Baltimore St.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 (M)  
FOR STATE  
HEALTH DEPT.

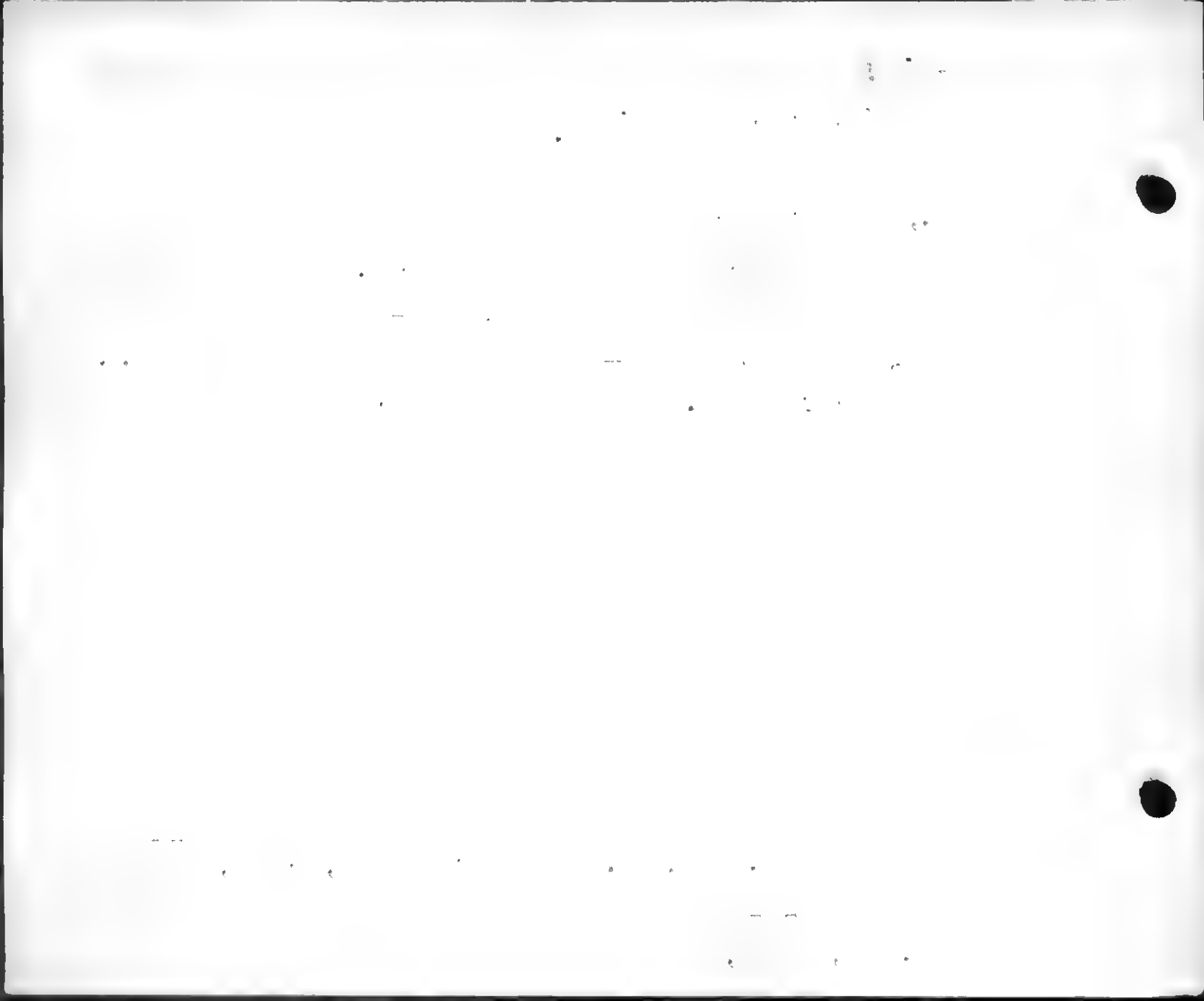
15194

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15192

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 7402 Wenig Avenue</b>		d. STREET ADDRESS <b>7402 Wenig Avenue 21222</b>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Chester Jr.</b> Last <b>Chester Jr.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10-1966</b>
9. AGE (in years last birthday) <b>3</b> yrs		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl Chester Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Sandra Dennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Parents, Earl &amp; Sandra Chester</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Due to</b> (c) <b>Due to</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		22. DATE SIGNED <b>11-9-1966</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		6800 Mornington Road, Dundalk, Maryland 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov-11-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Christ Lutheran Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Dundalk, Maryland 21222</b>
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25. RECD BY REGISTRAR <b>NOV 14 1966</b>	
26. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15195

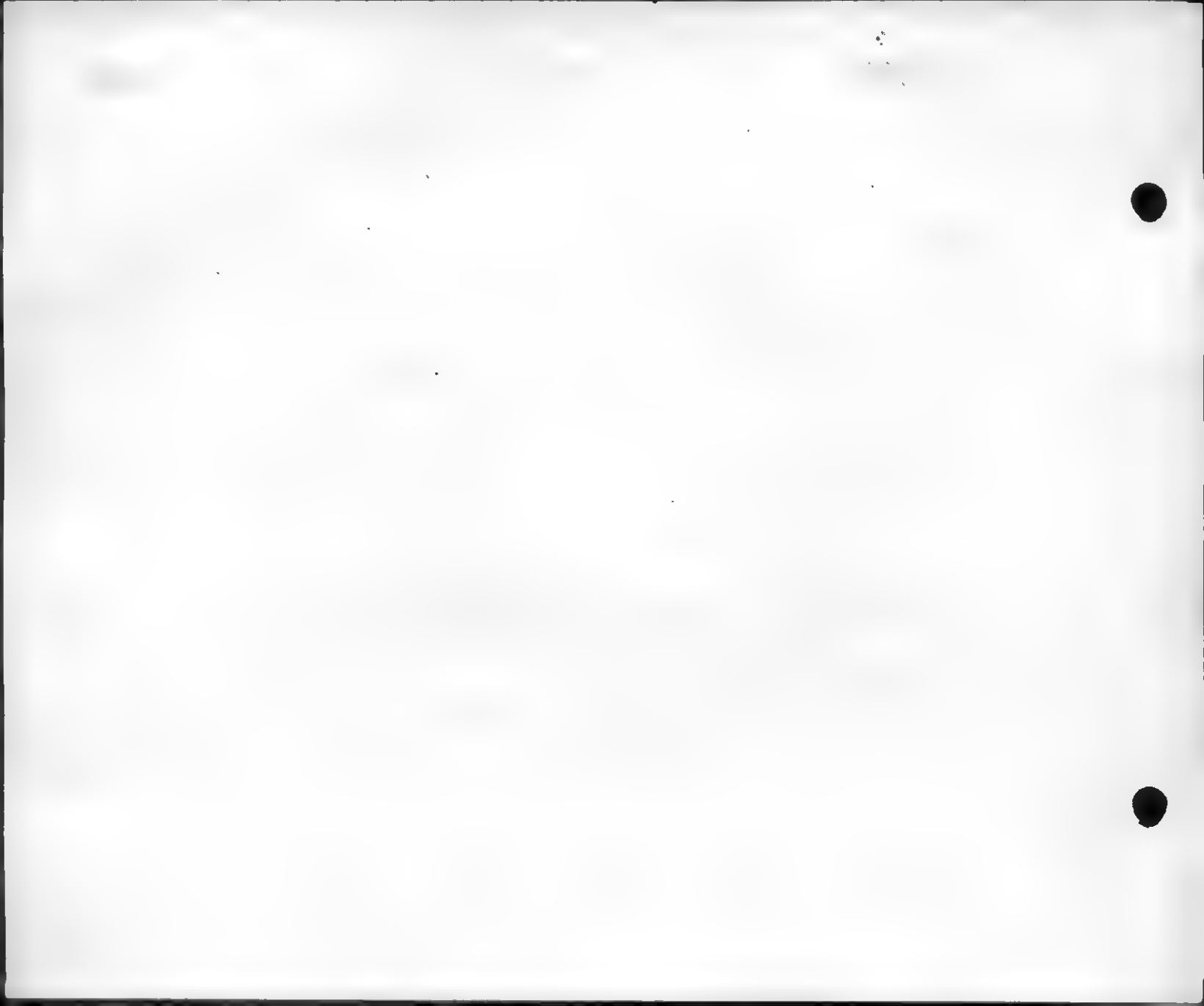
CERTIFICATE OF DEATH

15193

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bloomsbury Retreat</u> <u>200 BLOOMSBURY AVE</u>		d. STREET ADDRESS <u>308 THACKERAY AVE</u>	
3 NAME OF DECEASED (Type or print) <u>LILLIAN M. CHRISTIAN</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>7</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/2/88</u>
9 AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES BAILEY</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE DOWLING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT <u>CARTER CHRISTIAN</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8, 1963</u> , to <u>Nov 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 3, 1966</u> , and that death occurred at <u>6:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John A. Nesbitt Jr.</u>		22b. DATE SIGNED <u>11-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT JR.</u>		22d. ADDRESS <u>1059 Frederick Rd. Baltimore 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>	23d. LOCATION (City or Town) (County) (State) <u>HOWARD CO. MD.</u>
24. FUNERAL DIRECTOR <u>E.S. MACNAB</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

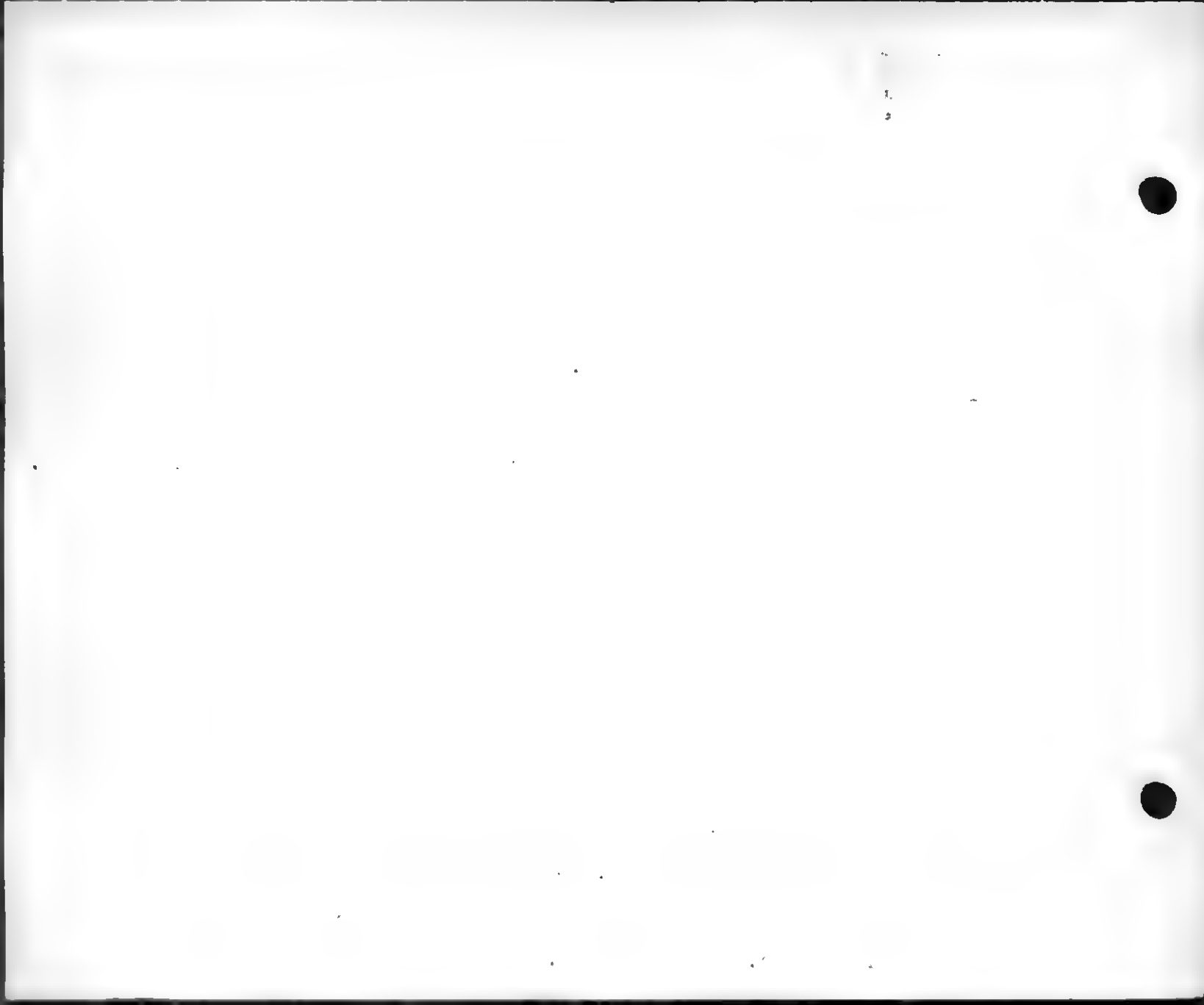
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15194

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) <input checked="" type="checkbox"/> a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson-rural</b>			c LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>St. Joseph Hospital</b>				d STREET ADDRESS <b>2912 Clearview Ave.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Clark</b>				4 DATE OF DEATH Month Day Year <b>11 21 19 66</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/30/1913</b>	9 AGE (In years last birthday) <b>53 yrs</b>	10 UNDER 1 YEAR Months Days Hours Min	11 UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Unknown</b>				14 MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16 SOCIAL SECURITY NO <b>216107732</b>		17. INFORMANT Address <b>Mrs. Florence M. Clark- 2912 Clearview Ave.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute placidyl intoxication</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Ingested overdose</b>					
20c TIME OF INJURY Month Day Year Hour o m p m <b>11 21 19 66</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>?</b>	20f (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		M.D. <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11/22/66</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <b>2912 Clearview Ave.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/25/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>				25a. RECD BY REGISTRAR DATE <b>NOV 23 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15197

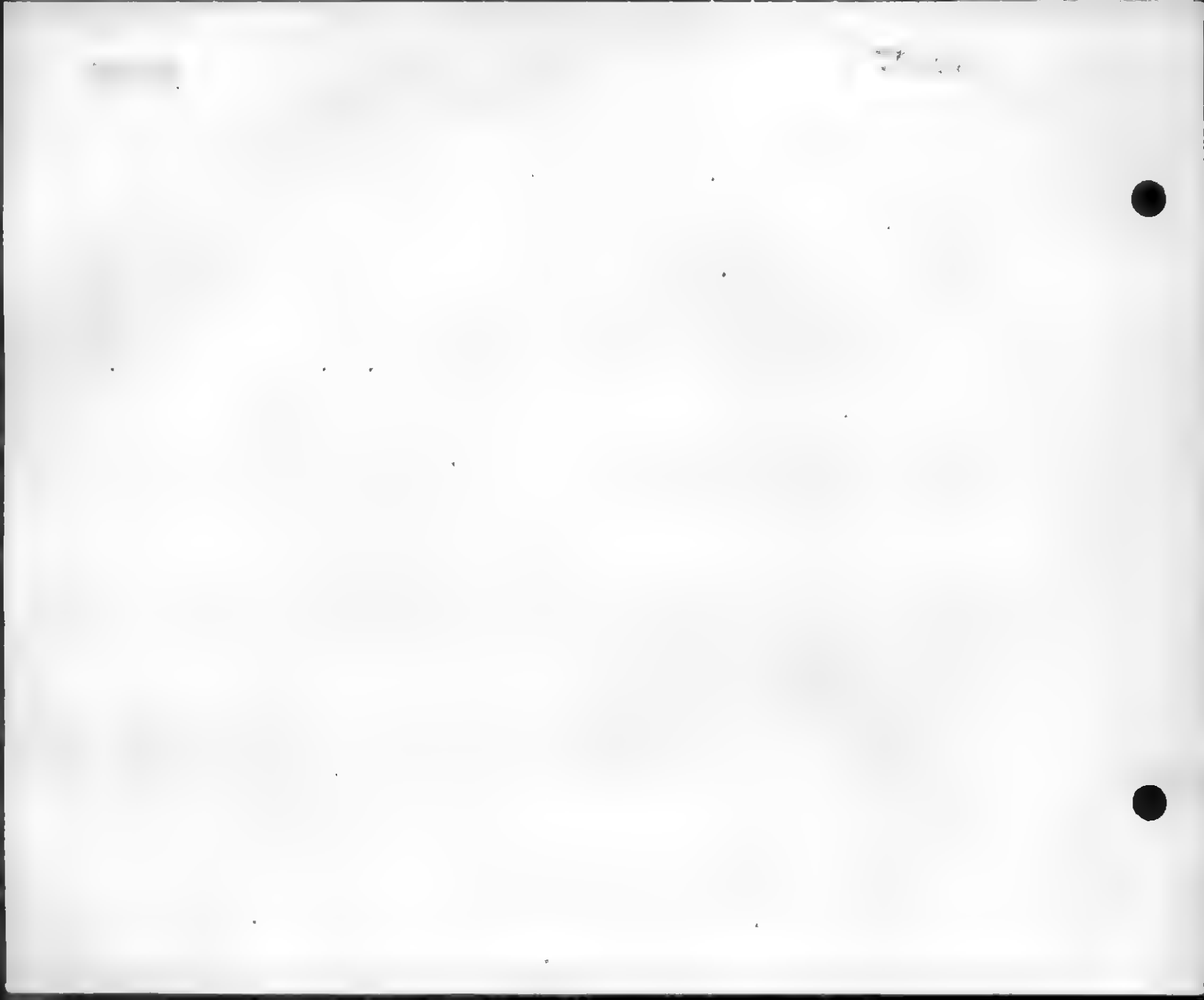
## CERTIFICATE OF DEATH

15195

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Balto.</u>		c. LENGTH OF STAY IN 1b <u>Doa-56 yrs--</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural , Baltimore</u>		d. STREET ADDRESS <u>2913 Conroy Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Josephs Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest J. Class</u>		4. DATE OF DEATH Month <u>November</u> , Day <u>8</u> , Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Christoph Class</u>	
14. MOTHER'S MAIDEN NAME <u>Sophia Wholen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-36-3759</u>		17. INFORMANT <u>Mrs. Elizabeth Class 2913 Conroy Ct.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis July 1966</u> DUE TO (b) <u>Myocardial Insufficiency since July 66</u> DUE TO (c) <u>Ventricular fibrillation Terminal</u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>1966</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Oct 20, 1966</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph G Hills</u>		22b. DATE SIGNED <u>Nov 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>RALPH G HILLS</u>		22d. ADDRESS <u>18 E EAGER ST BALTO MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

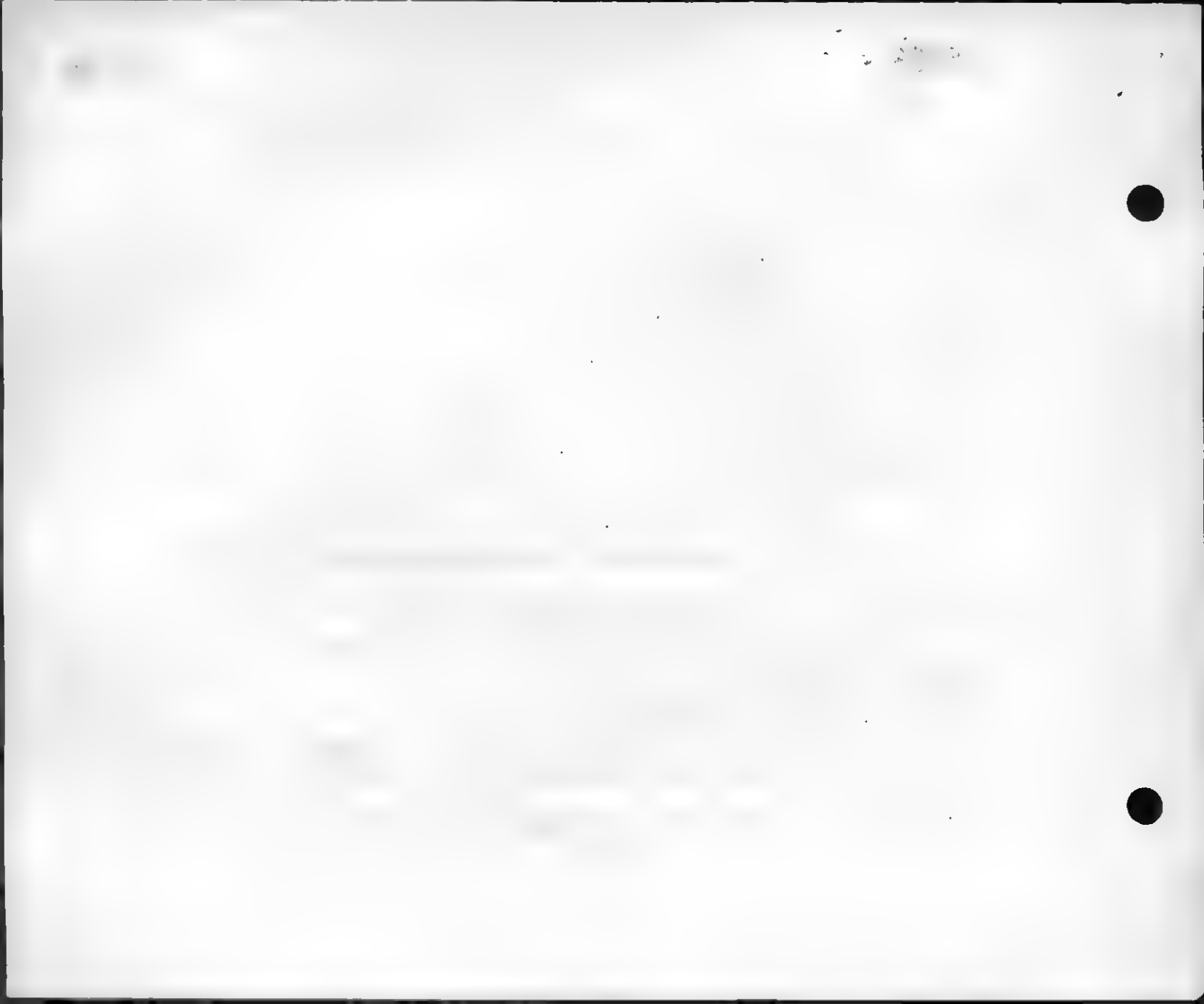
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15198

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15196

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN b. <u>31</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2409 Diana Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2409 Diana Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mollie</u> First <u>Mollie</u> Middle <u>Cohn</u> Last <u>Cohn</u> 4. DATE OF DEATH <u>Nov 11 1966</u> Month <u>Nov</u> Day <u>11</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 19, 1891</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Bernard Sopher</u> 14. MOTHER'S MAIDEN NAME <u>Sophia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unk</u> 17. INFORMANT <u>Mrs Jerome Schen</u> Address <u>Road 2409 Diana</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> DUE TO <u>Generalized Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Acute Carcinoma of Sigmoid</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>40</u> to <u>Nov 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 11</u> , 19 <u>66</u> , and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard Applefeld</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>WILLARD APPLEFELD</u>		22b. DATE SIGNED <u>11/11/66</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <u>5407 Park Heights N</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 13/66</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Tiferes Israel</u>		23d. LOCATION (City, town or county) (State) <u>Kredale, Md.</u>	
24. FUNERAL DIRECTOR <u>Sal Heiman</u> <u>Bro - 6010 Reet Rd</u>		25a. REC'D BY REGISTRAR <u>Charles J.</u> DATE <u>NOV 14 1966</u>	
25b. REGISTRAR'S SIGNATURE			



THE HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

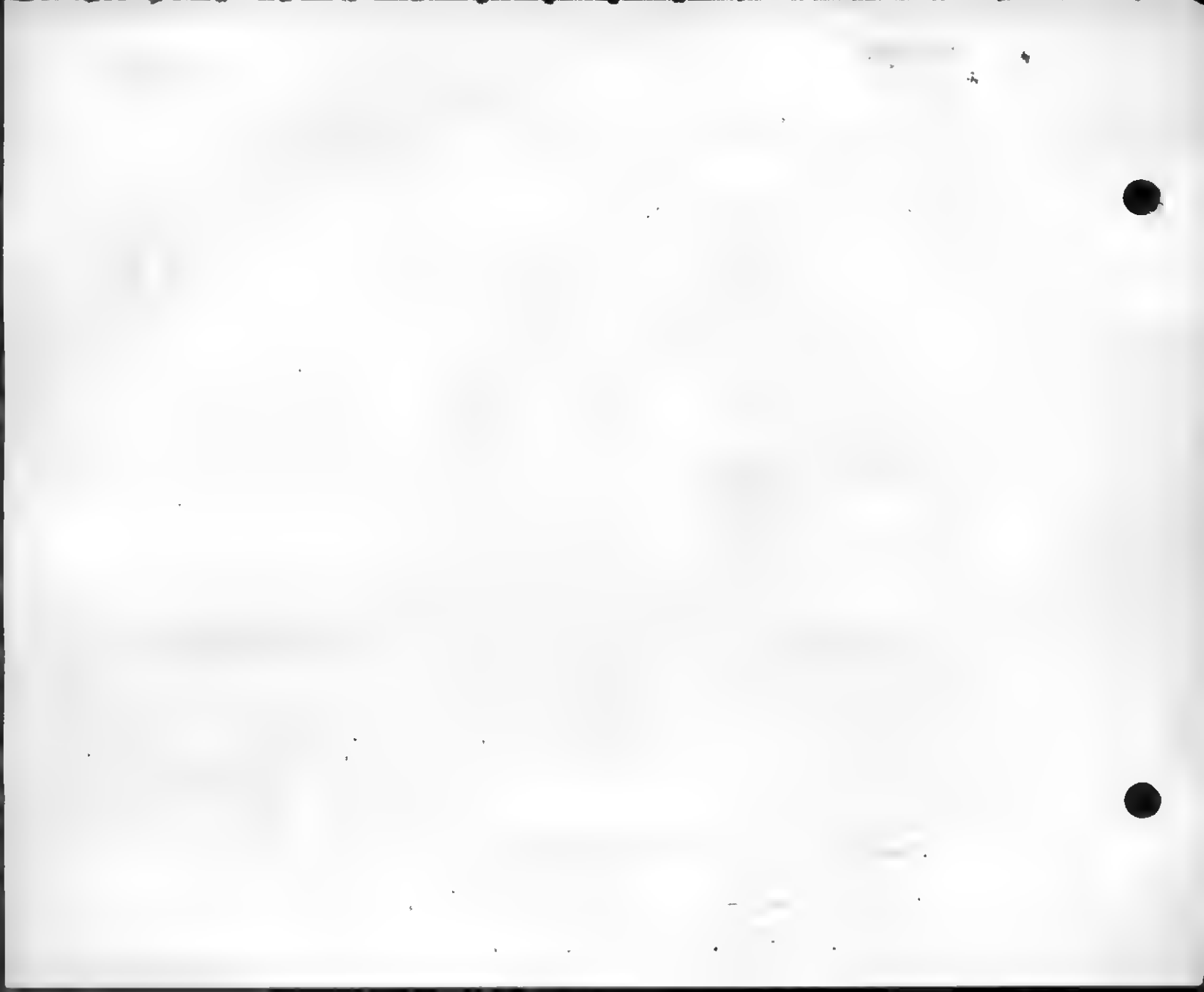
15199

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15197

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>2 month</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2000 Old Hartford Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Henry</b> Last <b>COLEMAN</b>		4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>1966</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/86</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>21</b> Hours <b>19</b> Min. <b>66</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>JAMES H. COLEMAN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA Mesenzahl</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-1701</b>		17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY FIBROSIS OF UNDETERMINED</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>ETIOLOGY</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (1) this hospital attended the deceased from <b>9/27</b> , 19 <b>66</b> , to <b>11/21</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>11/21</b> , 19 <b>66</b> , and that death occurred at <b>11/21</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>			22b. DATE SIGNED <b>11/21/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>			22d. ADDRESS <b>Mount Wilson, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>11-25-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>			25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



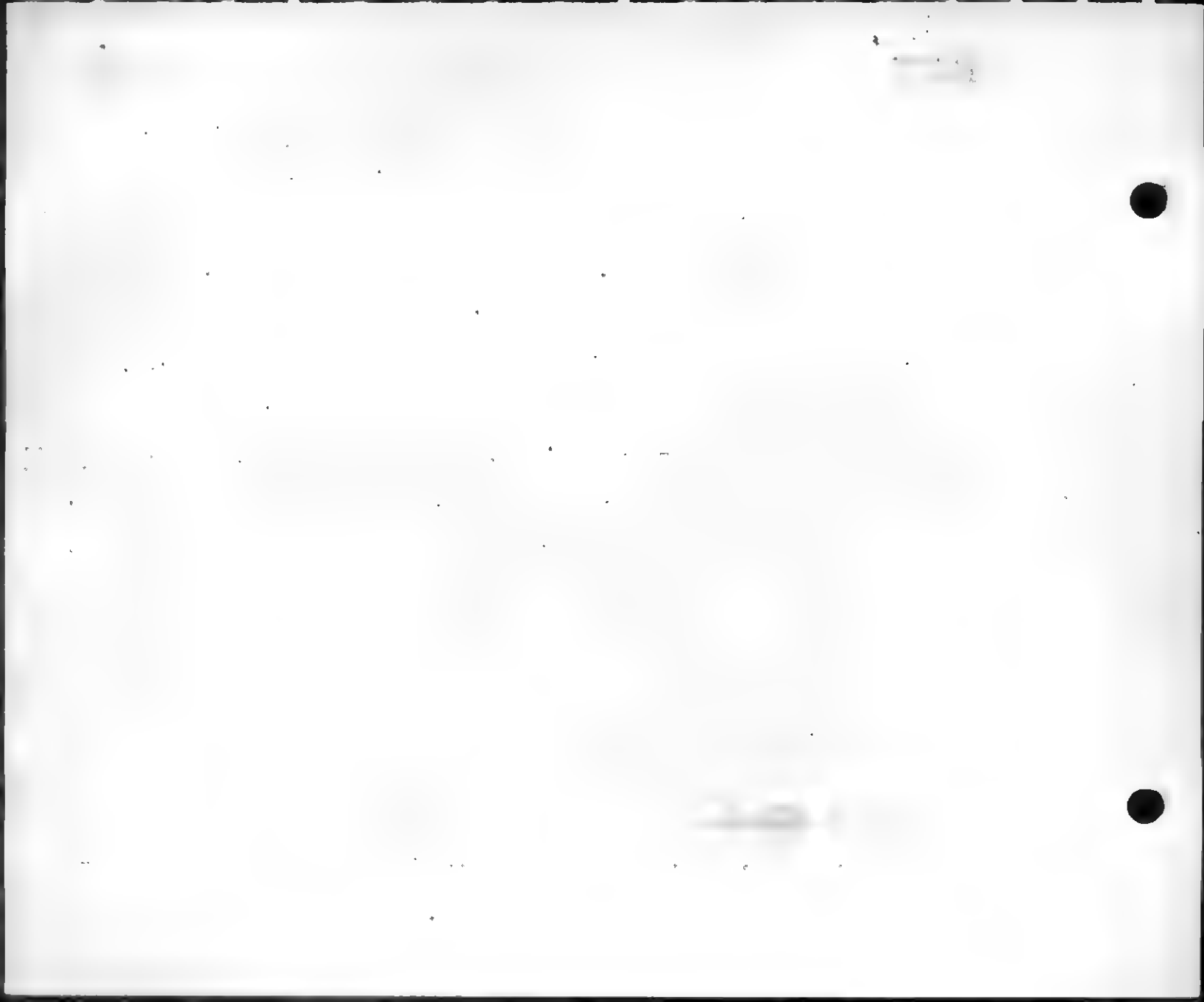
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15198

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 316 Tollgate Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie R. Collins		4. DATE OF DEATH Month Day Year Nov. 29 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY house work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Collins		14. MOTHER'S MAIDEN NAME Quilla Boardly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-52-2479	
17. INFORMANT Mrs. Mildred Vassar		Address 316 Tollgate Rd., Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitis DUE TO (c) Hypertensive C-V Disease			INTERVAL BETWEEN ONSET AND DEATH 18 yrs. 18 yrs. 14 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		22. DATE SIGNED 11-30-66	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd. Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/66	
23c. NAME OF CEMETERY OR CREMATORY Johnsville Cem.		23d. LOCATION (City, town or county) (State) Eldersburg, Maryland	
24. FUNERAL DIRECTOR H. J. Echhardt		ADDRESS Owings Mills, Md.	
25a. REC'D BY REGISTRAR DEC 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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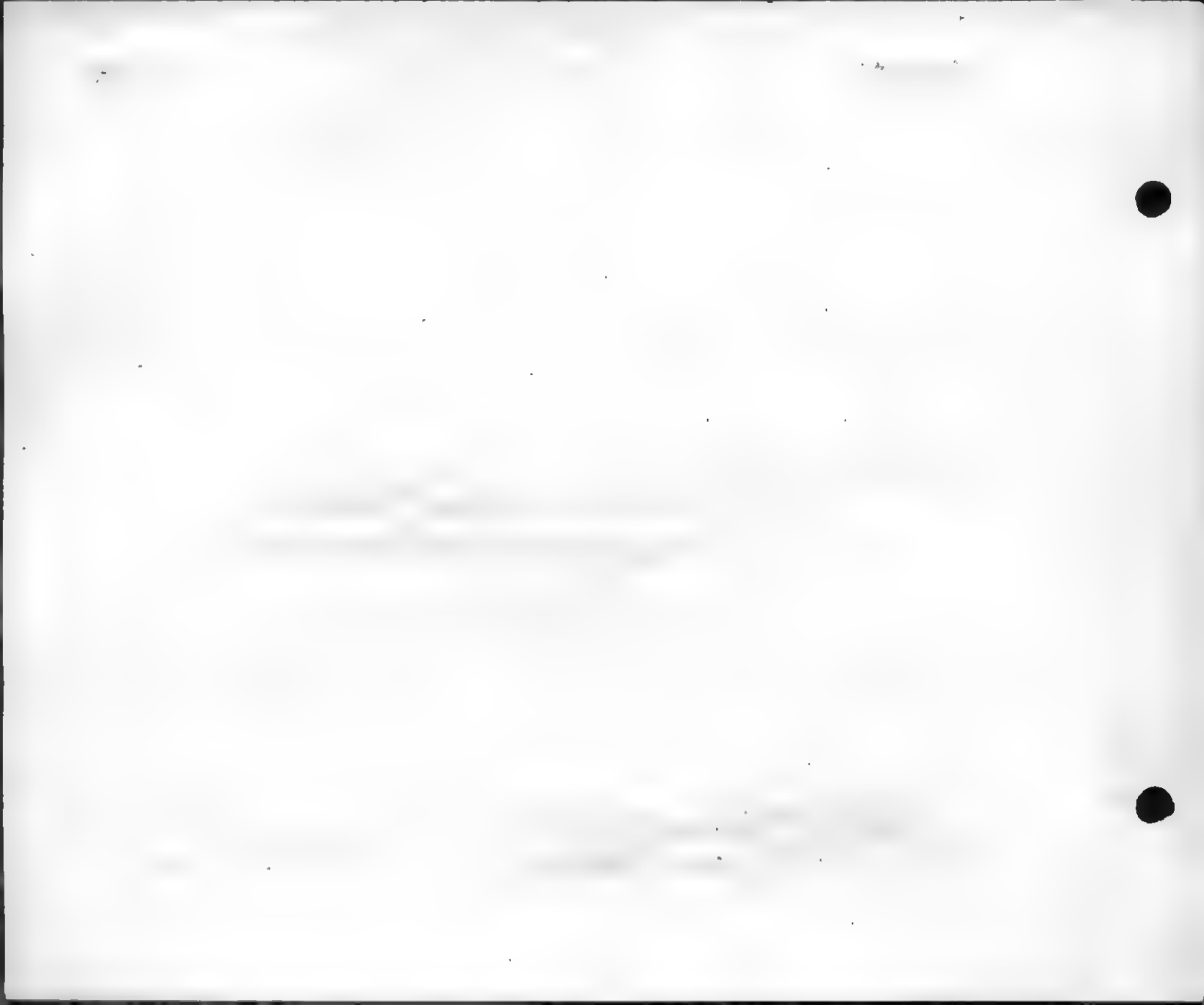
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15201

CERTIFICATE OF DEATH

15199

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mth3dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3511 Millvale Road</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Charles S. Conner</b>		4 DATE OF DEATH Month Day Year <b>11 - 5 1966</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 6, 1892</b>
9 AGE (In years lost birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>	
11 BIRTHPLACE (County & State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles S. Conner, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Cahill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>XXXXXX NO</b>		16. SOCIAL SECURITY NO. <b>XXXXXX</b>	
17. INFORMANT <b>Estelle Conner</b> Address <b>3511 Millvale Ave.</b>		Records: <b>SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure.</b> DUE TO (b) <b>Generalized Arteriosclerosis.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <b>Jan. 29</b> , 19 <b>66</b> , to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Narciso W. Carmona M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>NARCISO W. CARMONA</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-9-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

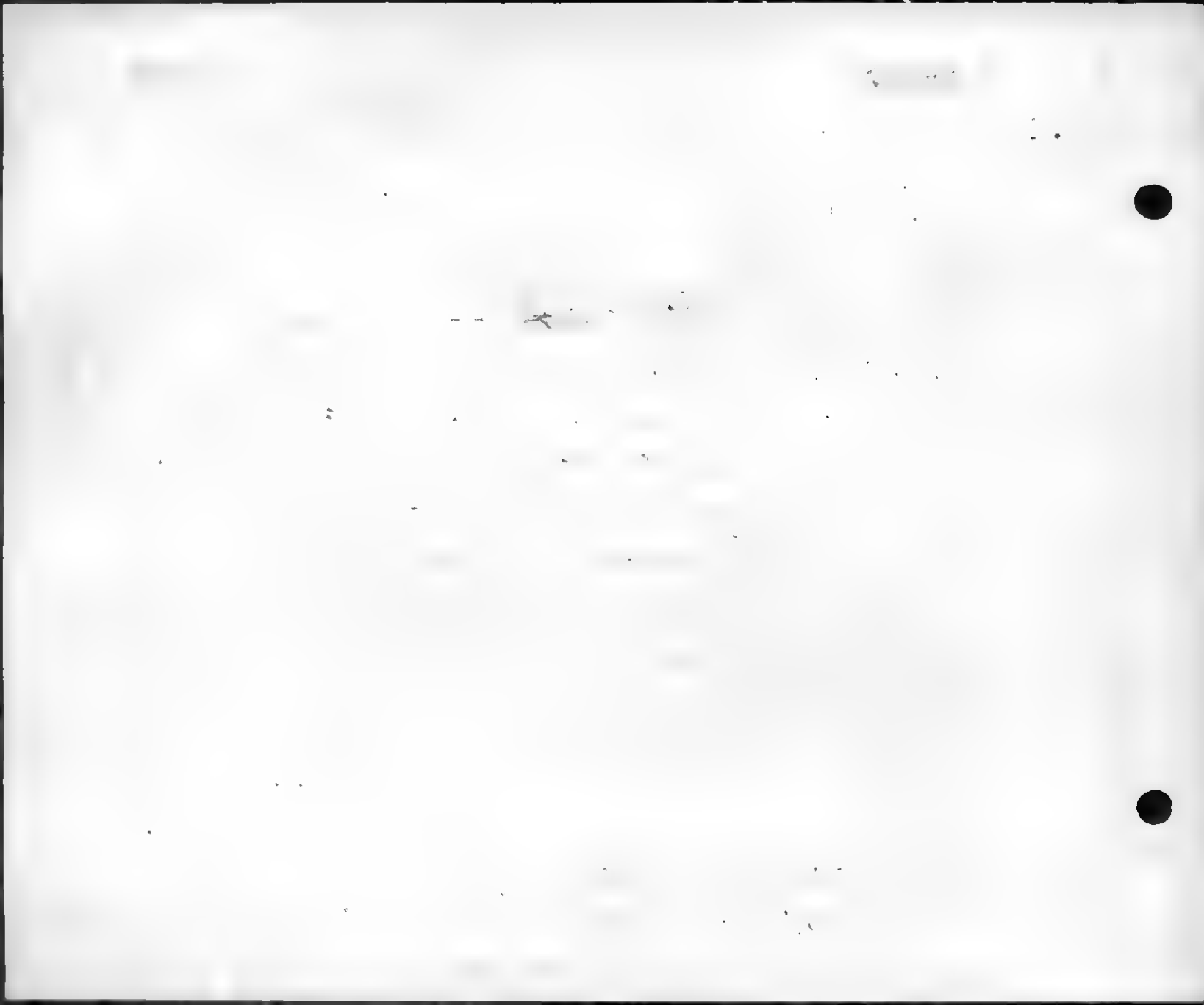
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15202

CERTIFICATE OF DEATH

15200

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				e. STREET ADDRESS <b>Baltimore, 6524 Cleveland Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>COURTNEY</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1966</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIAGE STATUS <b>UNMARRIED</b>		8. DATE OF BIRTH <b>7-4-1900</b>	9. AGE (In years last birthday) <b>66</b> yrs.	10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min <b>6</b>	11. IF UNDER 24 HRS Hours <b>6</b> Min <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEARER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Columbia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RAYMOND A COURTNEY</b>				14. MOTHER'S MAIDEN NAME <b>KATIE ORTMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>213-09-3730</b>		17. INFORMANT <b>LEO A. COURTNEY DUNDALK, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease, severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of right coronary artery</b> DUE TO (c) <b>due to</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A. TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>14</b> (this hospital) attended the deceased from <b>November 12, 1966</b> to <b>November 12, 1966</b> , that <b>14</b> (we) last saw the deceased alive on <b>November 12, 1966</b> , and that death occurred at <b>10:20 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>D. S. Govinda Rao</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov. 13, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.D. Govinda Rao, M.D.</b>				22d. ADDRESS <b>7620 York Road, 21204</b>			
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/15/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD</b>		23d. LOCATION (City or Town) (County) (State) <b>LANCASTER, PA.</b>	
24. FUNERAL DIRECTOR <b>Walter Burke Bradley, Dundalk, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

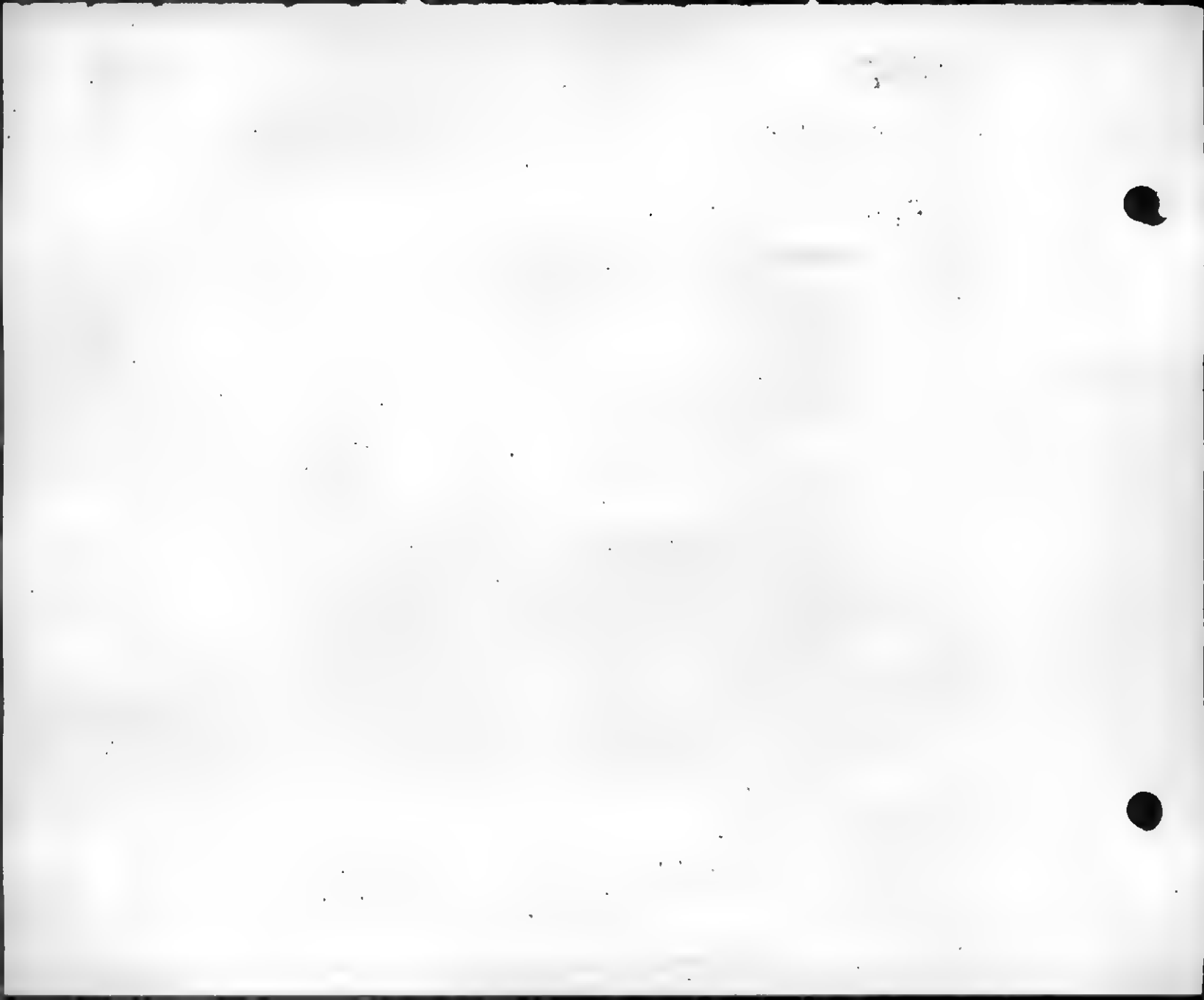


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15203 CERTIFICATE OF DEATH 15201

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 1, Box 146-C, LAUREL</b>	
c. LENGTH OF STAY IN 1b <b>ONE MONTH</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>			
3. NAME OF DECEASED (Type or print) First <b>CONGER</b> Middle <b>PUATH</b> Last <b>ASLES CONGER</b>		4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/21/22</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>13</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BABYSITTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EVERETT PUGH</b>		14. MOTHER'S MAIDEN NAME <b>FROCKA CLAYPOOL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>443-18-8816</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>con pneumonia with failure</b> DUE TO (b) <b>Extensive far Advanced pulmonary</b> DUE TO (c) <b>tuberculosis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/13/66</b> , 19 <b>66</b> , to <b>11-13-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-13-66</b> , 19 <b>66</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Tomblyn Bro. Home French Creek Md Va</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Harold Spencer Shook</b>		25a. REC'D BY REGISTRAR <b>550 Wash Blvd. Laurel, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 15 1966</b>	

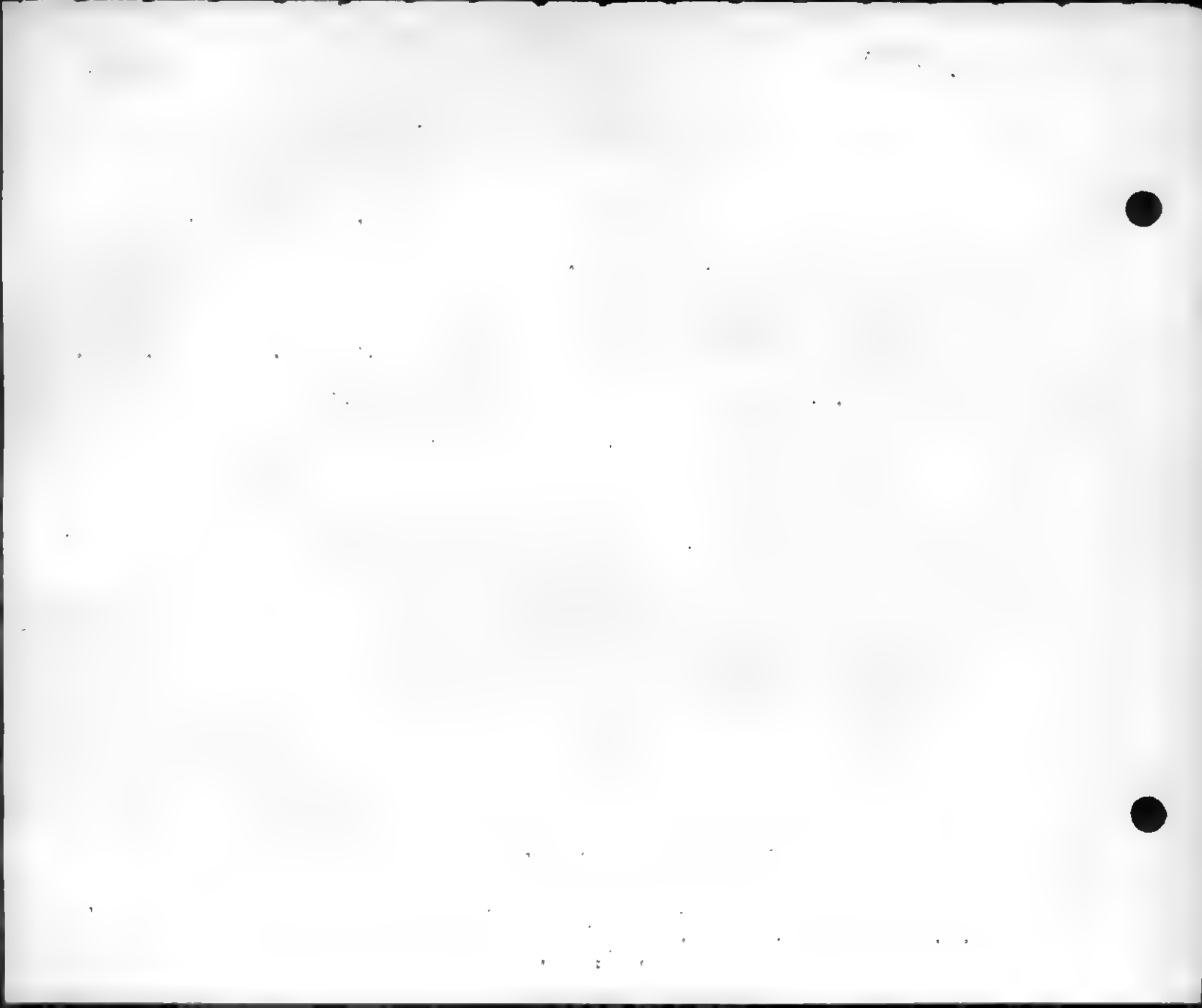


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15204					15202				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>					c. LENGTH OF STAY IN 1b <b>Baltimore</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>					d. STREET ADDRESS <b>3333 N. Charles St.</b>				
3. NAME OF DECEASED (Type or print) <b>Jessie E. Cox</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1966</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/20/1882</b>		9. AGE (in years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>George W. Cox</b>					14. MOTHER'S MAIDEN NAME <b>Jane B. Hoshall</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>220-46-4412</b>		17. INFORMANT <b>Miss Bernadette Judge</b> Address <b>(Same)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>4 x 100</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>Oct, 1966</b> to <b>Nov. 12, 1966</b> that (I) (we) last saw the deceased alive on <b>11/12</b> 1966, and that death occurred at <b>1:30 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Norman R. Freeman, Jr.</b>					22b. DATE SIGNED <b>11/12/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Norman R. Freeman, Jr.</b>					22d. ADDRESS <b>210 Northway</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/14/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





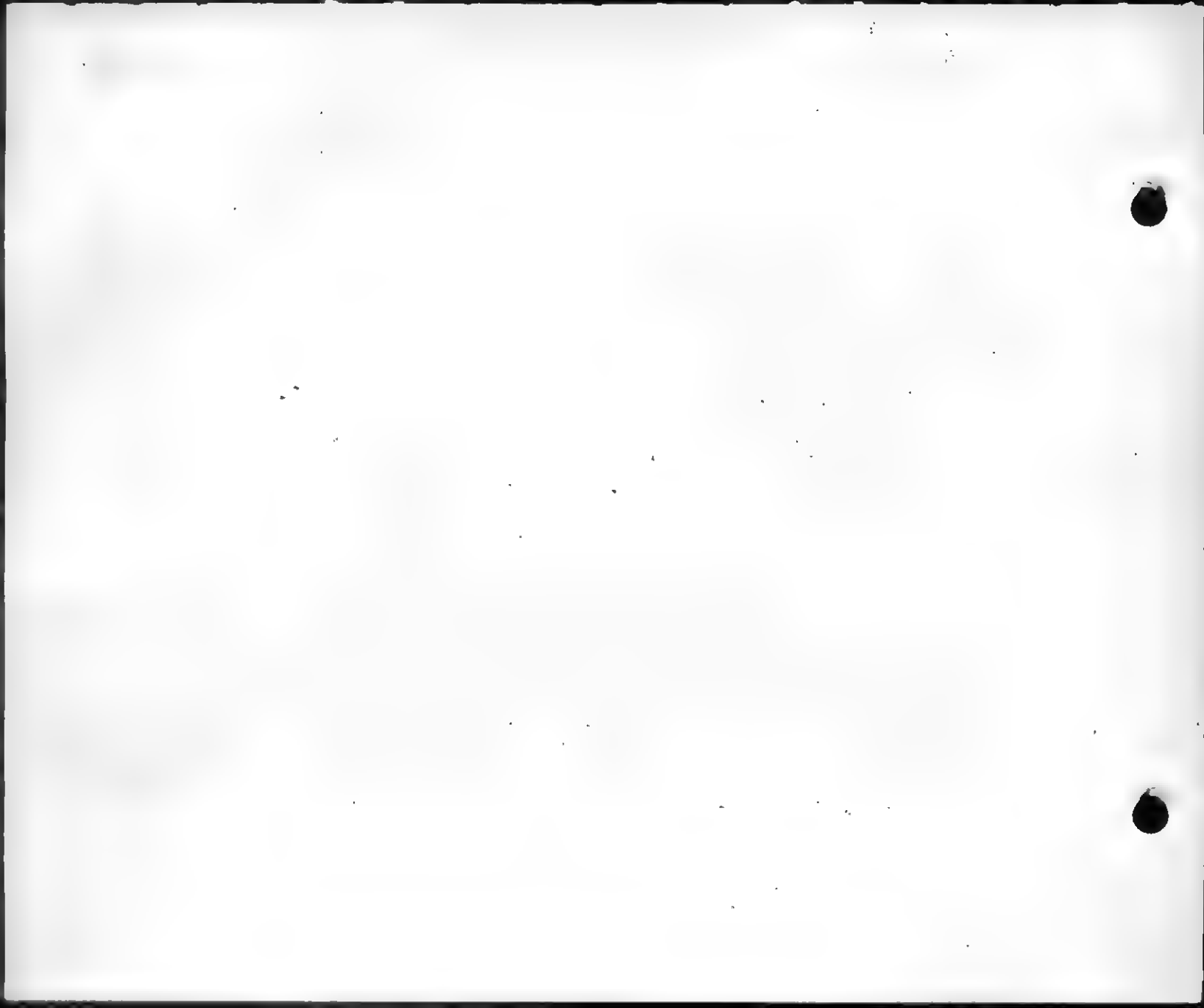
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>15205</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH</p> </div> <div> <p>15203</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>251 Linden Avenue</u>						d. STREET ADDRESS <u>251 Linden Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <u>Lula</u> Middle <u>Huntley</u> Last <u>Craycraft</u>			4. DATE OF DEATH			Month <u>November</u> Day <u>12</u> Year <u>1966</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 31, 1878</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Millard Filmore Huntley</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ellen Eason</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Mary Sumner, Towson, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Intestinal Obstruction</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7-10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/18, 1966</u> to <u>11/12, 1966</u> that (I) (we) last saw the deceased alive on <u>11/12, 1966</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles F. Donnell</u>						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>  </u>		
22d. ADDRESS <u>  </u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>Nov. 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gerton Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Gerton, N.C.</u>		
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

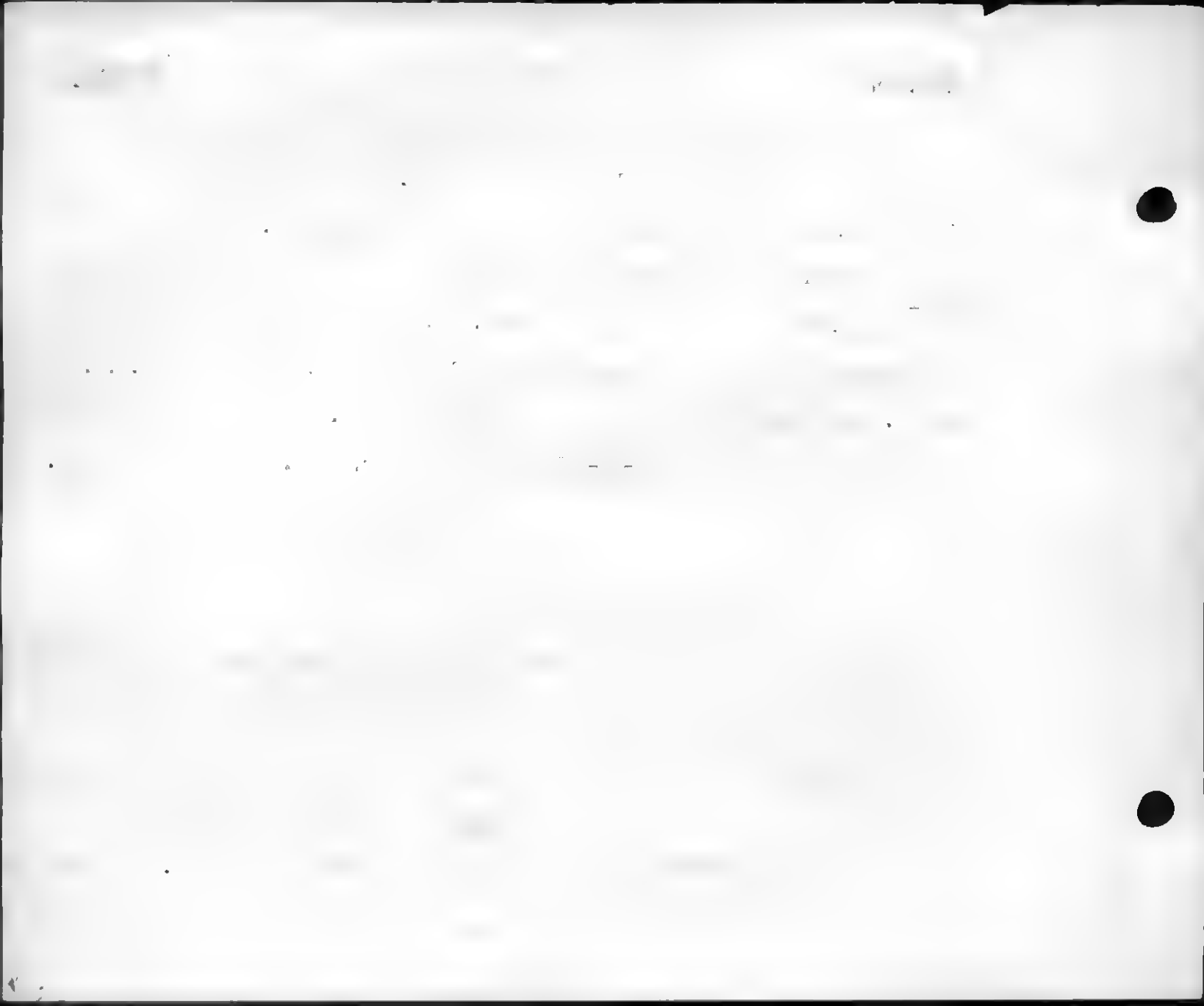
**15206**

**CERTIFICATE OF DEATH**

**15204**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE</b> c. LENGTH OF STAY in 1b <b>16 yrs</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CITY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>AUGSBURG LUTHERAN HOME 6811 Campfield Rd</b>				d. STREET ADDRESS <b>2575 Edmondson Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wilhelmina Margaret Cronhardt</b>				4. DATE OF DEATH Month Day Year <b>Nov. 5 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 22, 1884</b>	
9. AGE (In years last birthday) <b>82 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Art Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own school</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John C. Cronhardt</b>			
14. MOTHER'S MAIDEN NAME <b>Wilhelmina M. Wuest</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO <b>216-46-4717</b>				17. INFORMANT Address <b>Paul A. Hauer, Supt. 6811 Campfield Rd.</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>10 years</u>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Nov 5</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>Nov 5</u> , 19 <u>66</u> , and that death occurred at <u>6:40</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Earl L. Chambers</u>				22b. DATE SIGNED <u>11/5/66</u>		22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>	
22d. ADDRESS <b>4108 Liberty Heights Ave. Baltimore Md</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION REMAINS IN CHARGE		23b. DATE THEREOF <u>Nov 6 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ball's Creek</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Reinemann 6667 Hay Rd</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

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M  
1

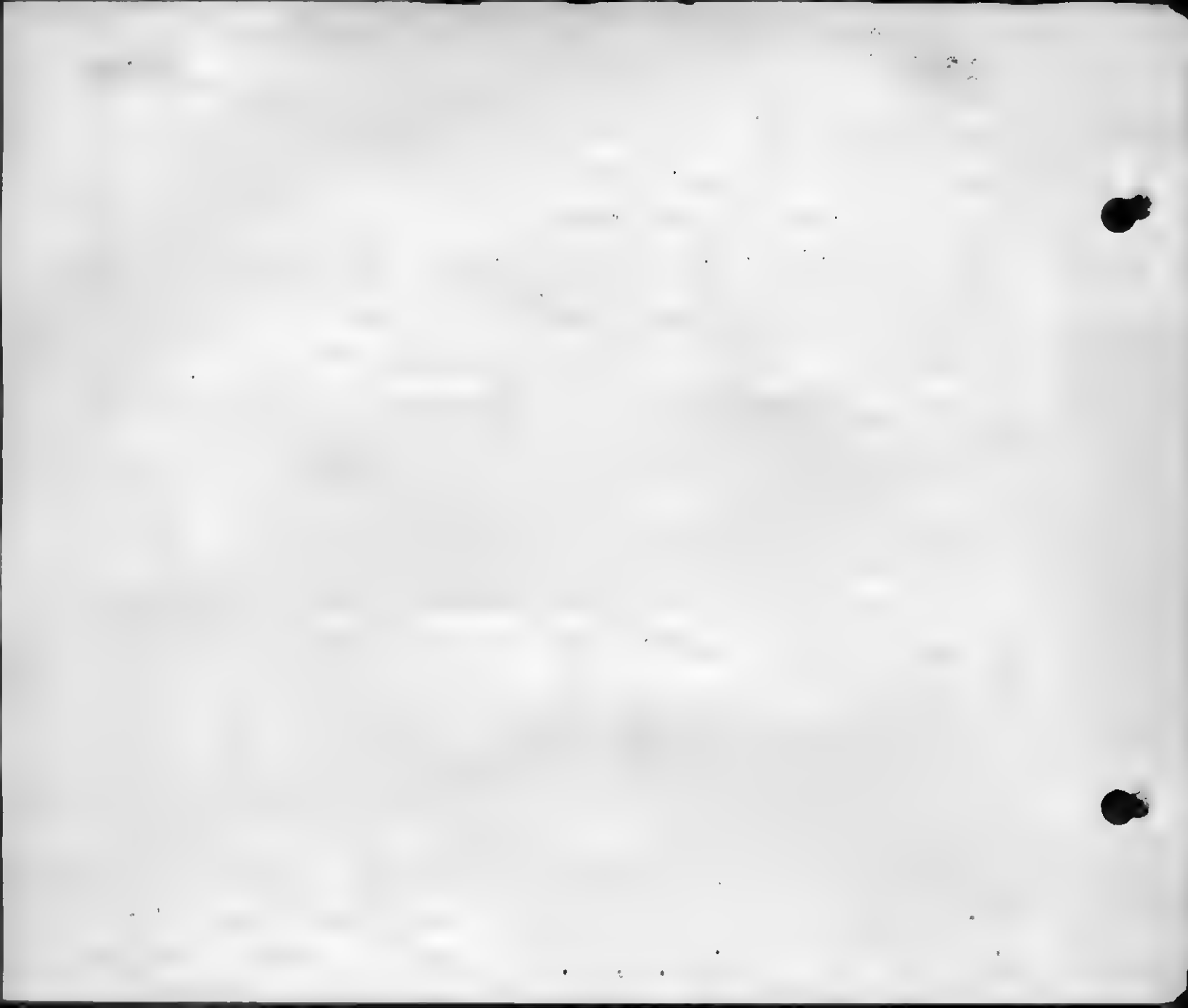
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15207

15205

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>5 1/2 yrs.</b>				d. STREET ADDRESS <b>410 E. Gittings Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>TOWSON CONVALESCENT HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MAYE HERSHNER CROSS</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1966</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 28, 1877</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>York Co. Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>HENRY HERSHNER</b>			
14. MOTHER'S MAIDEN NAME <b>CATHERINE Flinchbaugh</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>E.S. CROSS, Jr. 628 Chestnut Ave. Towson, Md.</b>				17. INFORMANT <b>E.S. CROSS, Jr. 628 Chestnut Ave. Towson, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Paralysis agitans</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 30 Oct 1966</b> to <b>2 Nov 1966</b> , that (I) (we) last saw the deceased alive on <b>30 Oct 1966</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Ernest S. Cross Jr.</b>				22b. DATE SIGNED <b>NOV 4 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>ERNEST S. CROSS JR</b>	
22d. ADDRESS <b>803 Med. Arts Bldg. Baltimore Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.-Burial 11/12/1966</b>				23b. DATE THEREOF <b>11/12/1966</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Randolph</b>				23d. LOCATION (City, town or county) <b>Randolph, N. H.</b> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 4 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15208

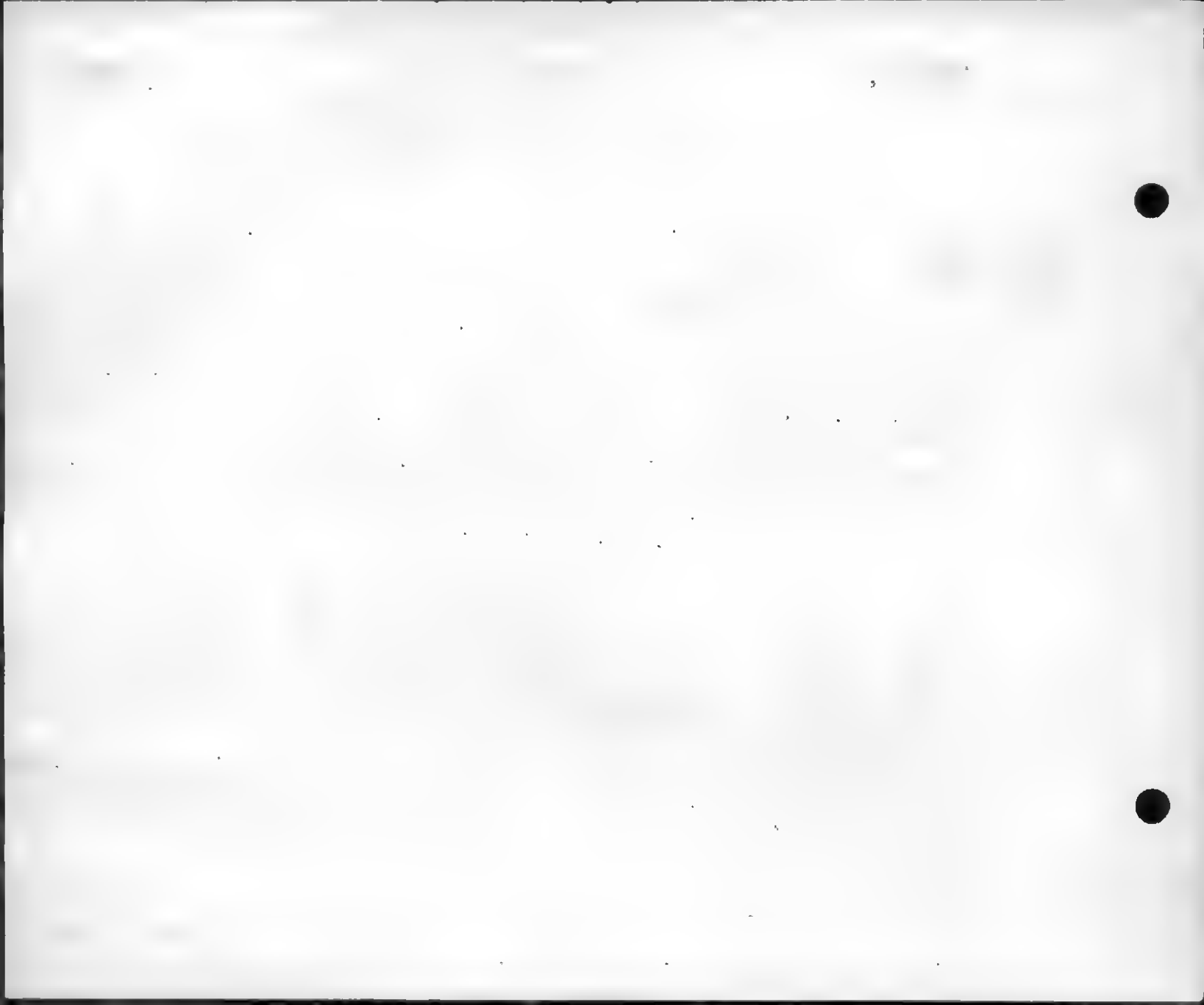
## CERTIFICATE OF DEATH

15206

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY in b <b>7 years</b>		d. STREET ADDRESS <b>2303 Ravenview Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2303 Ravenview Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Cummings</b> Last <b>Cummings</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1905</b>
9. AGE (In years lost birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b>22</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banking</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchantile Trust</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles M. Cummings</b>		14. MOTHER'S MAIDEN NAME <b>May E. Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-8111</b>	
17. INFORMANT <b>Garetta C. Cummings</b>		Address <b>2303 Ravenview Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>6-2-1952</b> to <b>11-27-1966</b> that (I) last saw the deceased alive on <b>11-17-1966</b> and that death occurred at <b>10A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert G. Bivert</b>		22b. DATE SIGNED <b>11-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.H. Bivert</b>		22d. ADDRESS <b>3105 N. Charles St. 21218</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-30-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc.</b>		ADDRESS <b>1050 York Rd.</b>	
25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15209

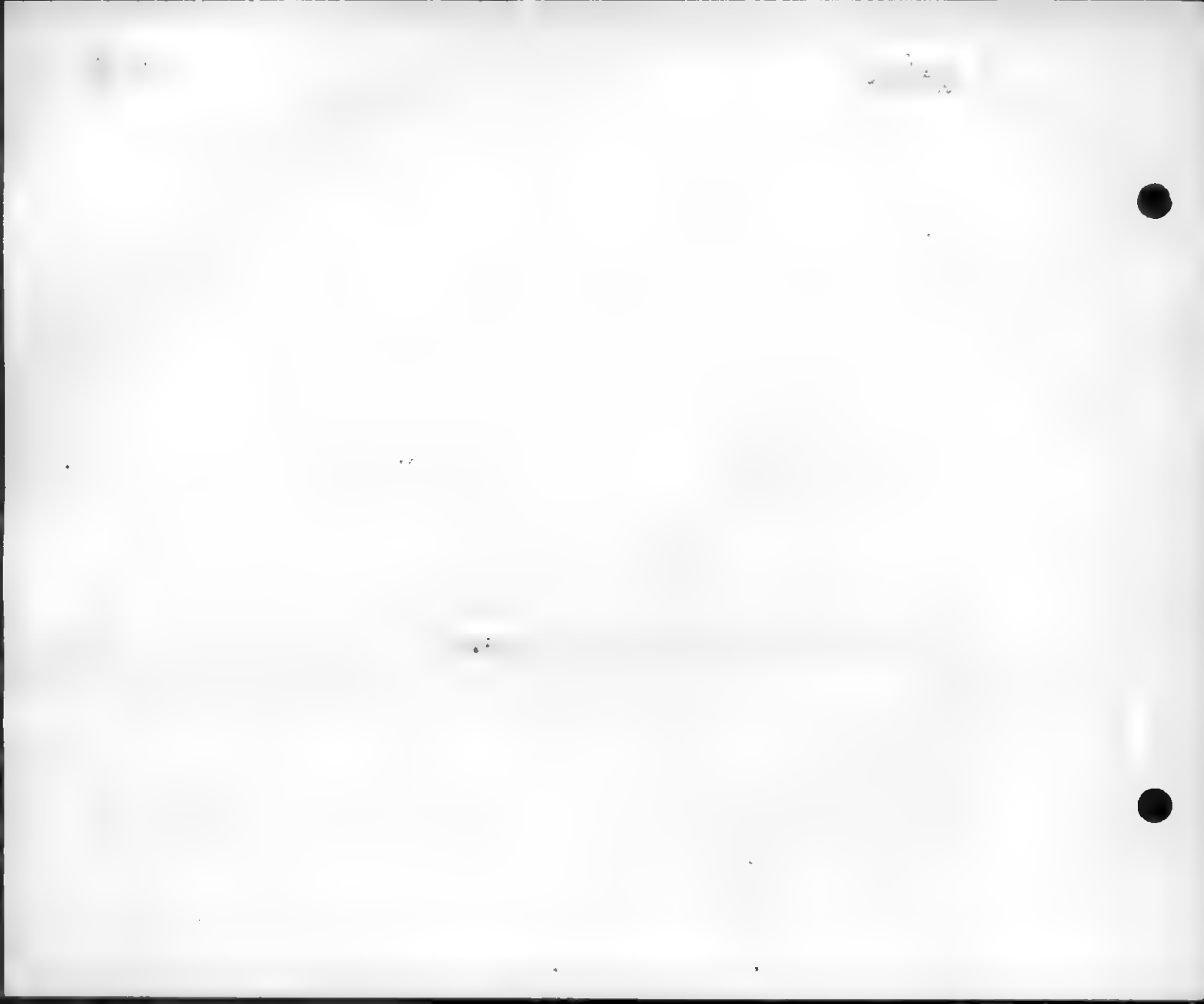
## CERTIFICATE OF DEATH

15207

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN 1b <u>Baltimore 21234</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Josephs Hospital</u>		d. STREET ADDRESS <u>1821 Wildwood Ave</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lee CUSTER</u>		4 DATE OF DEATH Month Day Year <u>November 17 19 66</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 1892</u>
9. AGE (In years last birthday) <u>74</u> Yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Leesburg, Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Molly ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Beale App Custer-</u>		Address <u>1821 Wildwood Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ureteral obstruction</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinomatosis, primary in cervix uteri.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>October 19, 1966</u> , to <u>November 17, 1966</u> , that (b) (we) last saw the deceased alive on <u>November 17 1966</u> , and that death occurred at <u>5:30 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Reynaldo Orjuela-Gomez, M.D.</u>		22b. DATE SIGNED <u>11/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Reynaldo Orjuela-Gomez, M.D.</u>		22d. ADDRESS <u>7620 York Rd., Baltimore, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/21/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. #14</u>		25a. REC'D BY REGISTRAR <u>NOV 18 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

15210

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15208

1. NAME OF DECEASED (Type or Print) <b>CARRIE R. DAVIS</b>		2. DATE AND HOUR OF DEATH <b>NOV 3-1966 11:05 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>BALTIMORE COUNTY</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>6103 WINDSOR MILL RD. BALTIMORE 7 MD.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before address on) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt Co.</b> C. CITY OR TOWN (If out of city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>6103 Windsor Mill Rd.</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>June 7-1876</b>
9. AGE (in years last birthday) <b>90</b>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <b>John Long</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S. A</b>	
13. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		14. MOTHER'S MAIDEN NAME <b>Martha Chillico</b>	
15. SOCIAL SECURITY NO. <b>218-54-1292</b>		16. INFORMANT <b>MRS PAULINE SMITH</b>	
17. ADDRESS <b>6103 WINDSOR MILL ROAD BALT.</b>		18. CAUSE OF DEATH <b>Pneumonia</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. INTERVAL BETWEEN ONSET AND DEATH	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD</b>		22. I certify that (I) (this hospital) attended the deceased from <b>July 1966</b> to <b>11/3 1966</b> that (he) (we) last saw the deceased alive on <b>11/3 1966</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>J. E. H. H.</b>		23B. DATE SIGNED <b>11/4/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. J. E. H. H.</b>		23D. ADDRESS <b>Randallstown Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>Nov. 6</b>	24C. NAME OF CEMETERY or CREMATORY <b>STEVENSVILLE</b>	24D. LOCATION (City, town, or county) (State) <b>STEVENSVILLE MD.</b>
25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 10 1966</b>		25B. NAME OF REGISTRAR <b>Charles Judge</b>	
25C. FUNERAL DIRECTOR <b>Edgar L. Lane</b>		25D. ADDRESS <b>Church Hill</b>	

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15211

CERTIFICATE OF DEATH

15209

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>9 DAYS</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d STREET ADDRESS <b>3406 DUVAL AVENUE</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JAMES J DAVIS</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 20, 19 66</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JULY 7, 1889</b>	9 AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINISTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES N. DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>NANCY HARRIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO <b>219 14 0994</b>		17. INFORMANT Address <b>CLIN REC VAH FT HOWARD MARYLAND</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>CARCINOMA OF COLON WITH METASTASIS</b>						INTERVAL BETWEEN DEATH AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from <b>NOV. 11, 1966</b> to <b>NOV. 20, 1966</b> , that (A) (we) last saw the deceased alive on <b>NOV. 20, 1966</b> , and that death occurred at <b>12:58 P.M.</b> from causes and on the date stated above.							
22a SIGNATURE <i>S. Premasathian M.D.</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11 20 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DILOK PREMASATHIAN M.D.</b>				22d. ADDRESS <b>VET ADM HOSP FT HOWARD MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>11/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Anne Arundel County, Md</b>	
24. FUNERAL DIRECTOR <b>Nutter Funeral Home</b> <b>3035 W. NORTH AVE.</b> <b>BALTIMORE, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>		25b REGISTRAR'S SIGNATURE <i>new judge</i>	

MEDICAL CERTIFICATION

08

1117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15212

CERTIFICATE OF DEATH

15210

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN 1b <b>3 Mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1609 Pots Spring Rd.</b>		d. STREET ADDRESS <b>1516 Kingsway Rd. 21218</b>	
3 NAME OF DECEASED (Type or print) <b>Clinton Edward Day</b> First Middle Last		4 DATE OF DEATH <b>Nov. 28, 1966</b> Month Day Year	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1891</b>
9 AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Linotype</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Waldoboro, Me.</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13 FATHER'S NAME <b>Lincoln Day</b>		14 MOTHER'S MAIDEN NAME <b>Sarah ?</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes. W.W.I</b>		16. SOCIAL SECURITY NO. <b>108 09 4256</b>	
17. INFORMANT <b>Agnes Day, 1516 Kingsway Rd. Baltimore, 18</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertrophy of R. Kidney</b> <b>180 X</b> DUE TO (b) <b>Mitastasis over entire body</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>7 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1939</b> to <b>Nov. 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 1966</b> , and that death occurred at <b>12:30 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Laurence C. Cook</b>		22b. DATE SIGNED <b>Nov. 28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. COOK</b>		22d. ADDRESS <b>6805 York Rd. Baltimore 21212 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Nov. 30, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 1 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15213

## CERTIFICATE OF DEATH

15211

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE DUNDALK 21222</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>BROADSHIP ROAD</b> <del>3 BAYVIEW ROAD</del>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THORNTON -- DEANE</b>				4. DATE OF DEATH Month Day Year <b>11/4/66</b> 19			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 5, 1919</b>		9. AGE (In years last birthday) <b>47 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BENNETT CAB</b>		11. BIRTHPLACE (County & State, or foreign country) <b>RUCKERSVILLE, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LESTER DEANE</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES TAYLOR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>228 14 0620</b>		17. INFORMANT <b>VA HOSPITAL</b> <b>CLINICAL RECORDS</b> <b>FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC ALCOHOLISM, LAEMNEC'S CIRRHOSIS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 30</b> , 19 <b>66</b> , to <b>NOV 4</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>NOV 4</b> , 19 <b>66</b> , and that death occurred at <b>4:35 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Peter G. Burch</i> <b>PETER G. BURCH, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER G. BURCH, M.D.</b>				22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/7/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RUCKERSVILLE CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>RUCKERSVILLE VIRGINIA</b>	
24. FUNERAL DIRECTOR <i>Walter Brooks Bradley</i> <b>WALTER BROOKS BRADLEY FUNERAL HOME</b> <b>WILLOW SPRING ROAD, BALTIMORE, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>NOV 7 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1121

1121

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15214

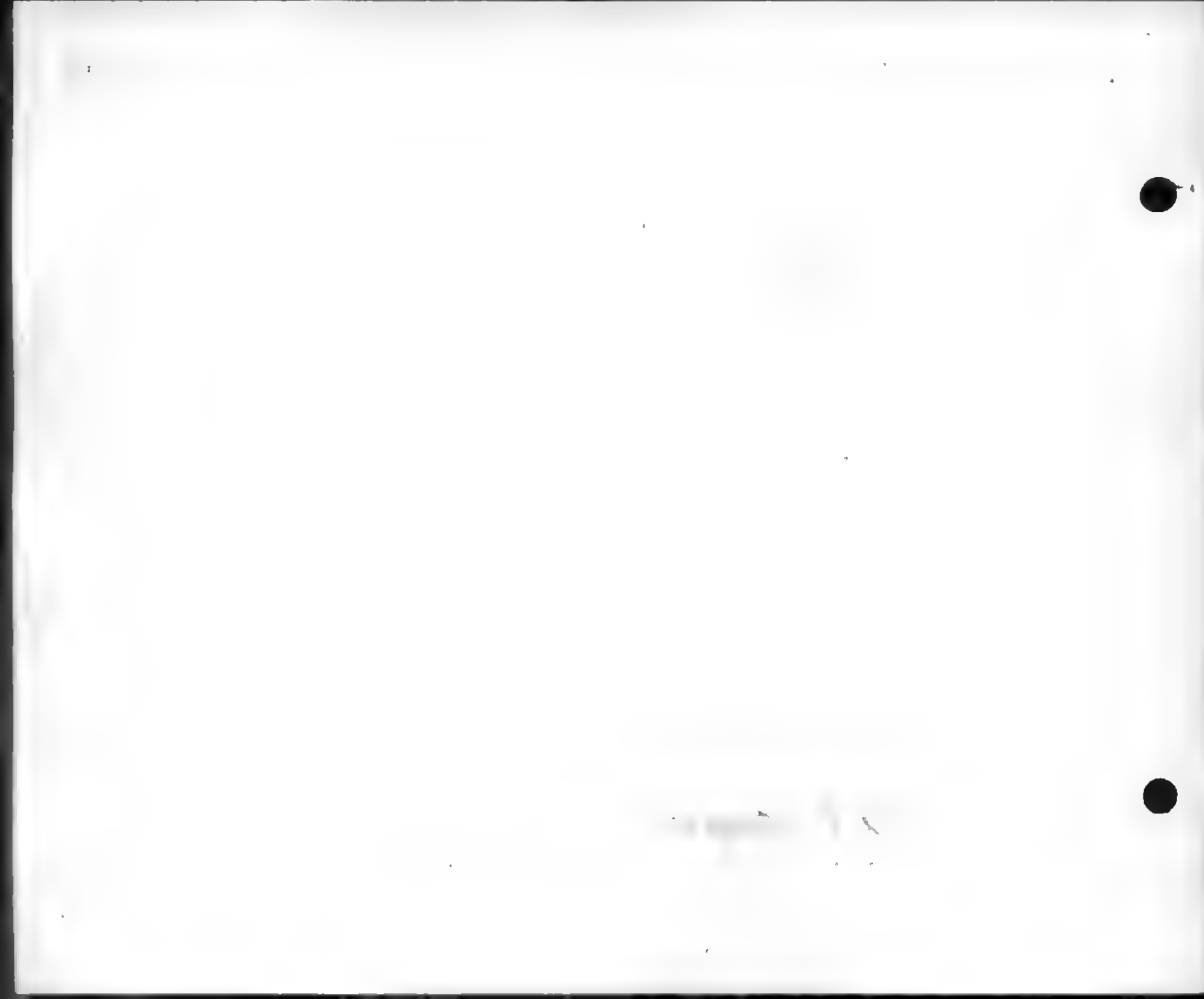
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15212

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>				c LENGTH OF STAY IN b <b>D.O.A.</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County Gen. Hosp.</b>				e STREET ADDRESS <b>6817 Fox Meadow Rd.</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Michael Meyer Dexter or Meyer Zelasko</b>				4 DATE OF DEATH Month Day Year <b>November 20 19 66</b>			
5 SEX <b>Male</b>	6 CO. OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 23, 1916</b>	9 AGE (In years last birthday) <b>49</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>			10b KIND OF BUSINESS OR INDUSTRY <b>Paint</b>		11 BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13 FATHER'S NAME <b>Hirsh Zelasko</b>			14 MOTHER'S MAIDEN NAME <b>Freida ?</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. II</b>			16 SOCIAL SECURITY NO <b>133-09-0816</b>		17 INFORMANT Address <b>Mrs. Claire W. Dexter, 6817 Fox Meadow Rd., Balto., Md.</b>		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>none</b>			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>none</b>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Caples</b>			M.D. <b>D. D. Caples, M. D.</b>		22. DATE SIGNED <b>11-22-66</b>		
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>			6 Hanover Rd., Reisterstown, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11-22-66</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mikro Kodesh Beth Israel</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown Rd</b>				25a RECD BY REGISTRAR DATE <b>NOV 25 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1 (M)

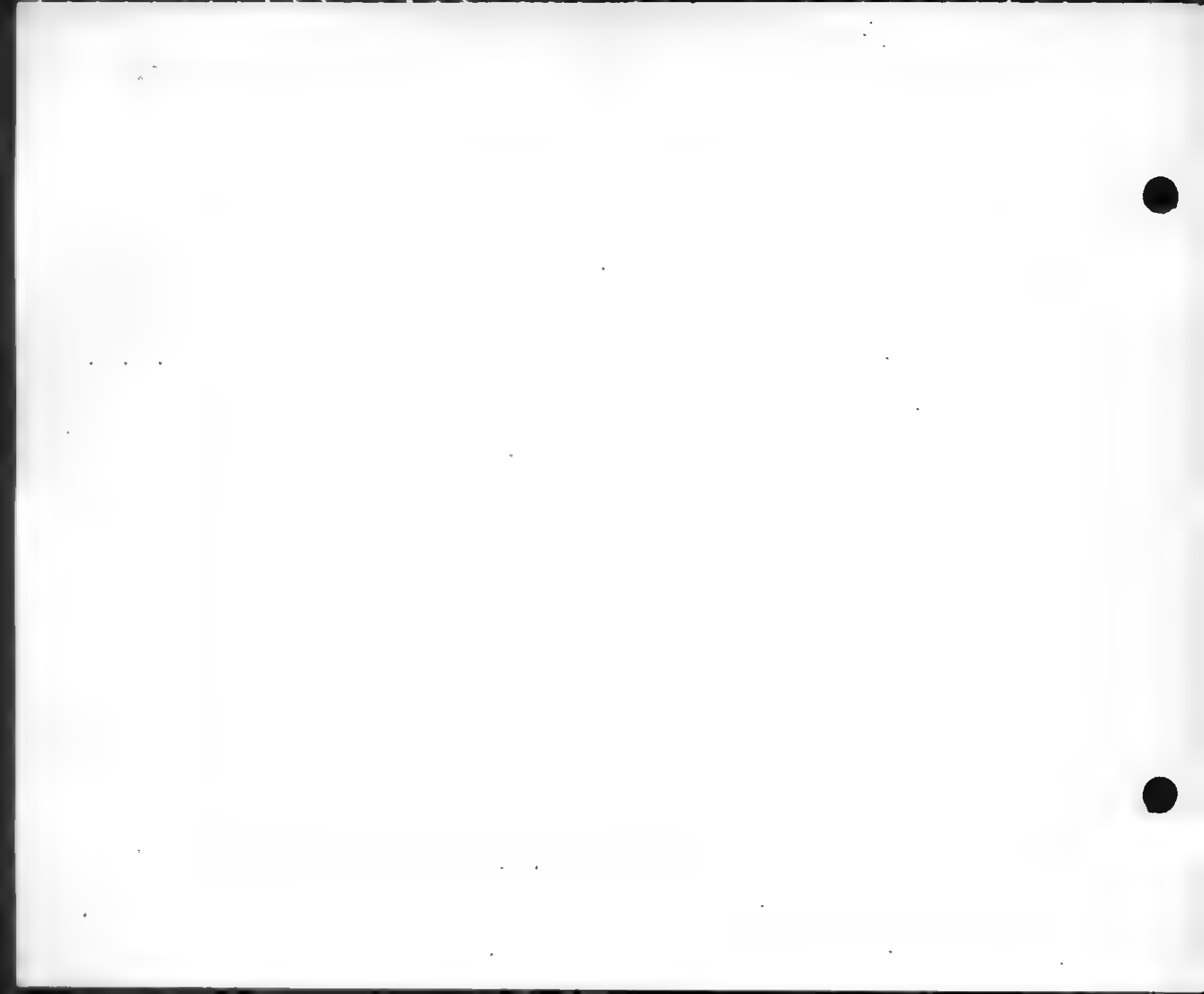
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15215

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15213

1. PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c LENGTH OF STAY IN ID <b>76 Years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2909 Morrison Lane</b>		d STREET ADDRESS <b>2909 Morrison Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>C.</b> Last <b>Dillian</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/89</b>
9. AGE (in years last birthday) yrs <b>76</b>		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alonzo Morrison</b>		14. MOTHER'S MAIDEN NAME <b>Christene Dennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT (Daughter) <b>Mrs. Ann Woelfer, 2909 Morrison Lane</b>		Address <b>Edgemere, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)
20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b> M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>11/21/66</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>105 Main St. Dundalk</b> Address (Street, city, town, or county) <b>Maryland 21222</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 23, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Carmel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>John J. Duda</b> 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15216						15214					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY <b>Baltimore</b>						a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4423 Alan Ave.</b>						b. COUNTY <b>Baltimore</b>					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Baltimore, Md</b>						d. STREET ADDRESS <b>4423 Alan Ave.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>ROBERT L. DONOVAN</b>			First Middle Last			4. DATE OF DEATH <b>Nov. 1, 1966</b>			Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 12, 1914</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept. Emp. Security</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Woodstock, Md</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>William D. Donovan Sr</b>						14. MOTHER'S MAIDEN NAME <b>M. Grace Brown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-05-4963</b>		17. INFIRMANT Address <b>Miss M. Grace Donovan, 4423 Alan Ave. Balto. Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory failure</b> <b>5020</b> DUE TO (b) <b>Myocardial Degeneration + Cor Pulmonale</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Chronic Bronchitis + Emphysema</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>1 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1 Nov</b> , 19 <b>66</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>William J. Bryson</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3 Nov 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>William J. BRYSON</b>						22d. ADDRESS <b>4605 Edmondson Ave.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-4-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus</b>		23d. LOCATION (City, town or county) (State) <b>Woodstock, Md</b>			
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

11



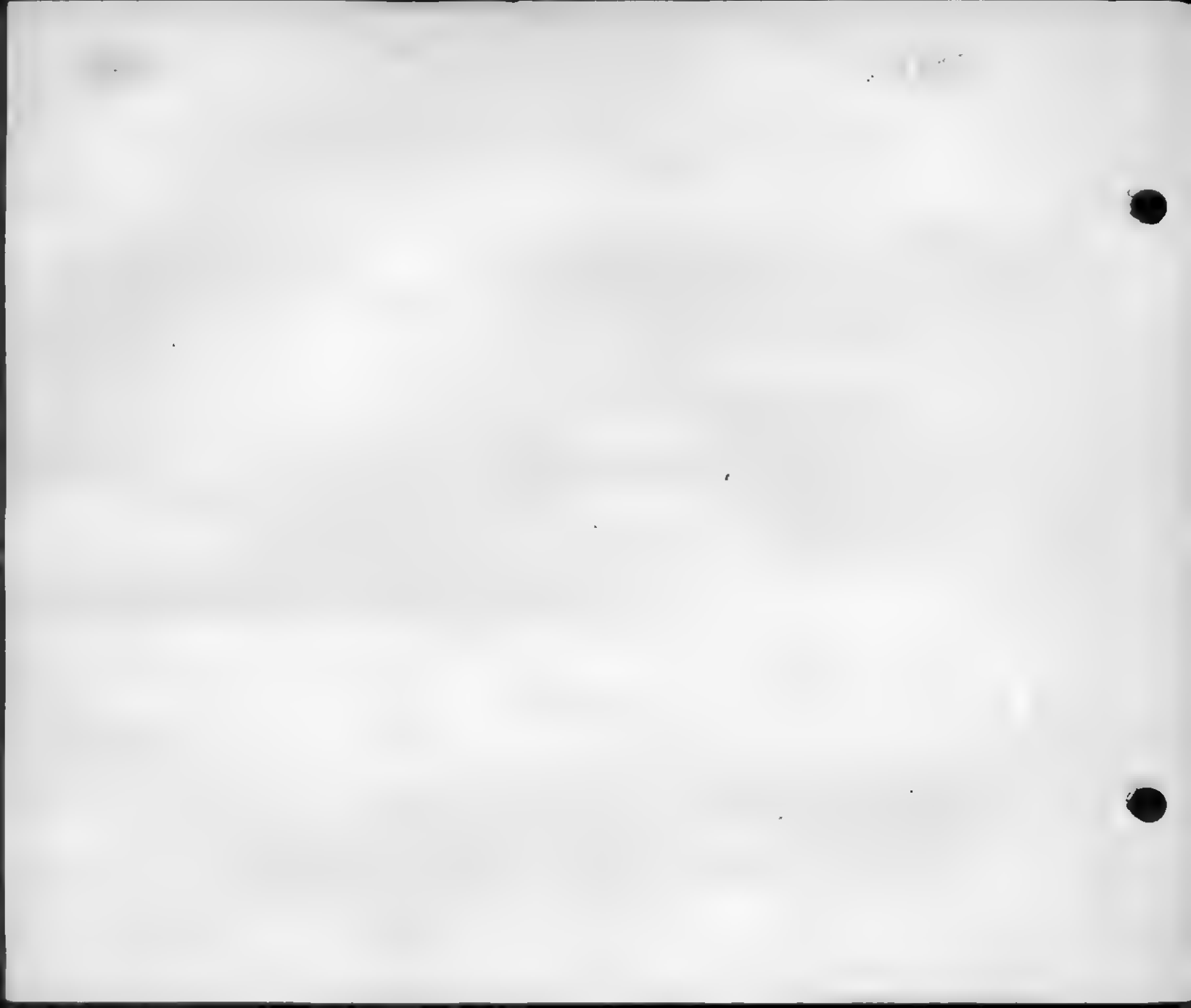
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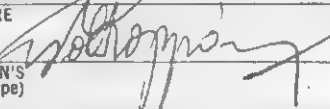

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 5-63

<div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div>15217</div> <div>15215</div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armaccst Nursing Home</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>429 N. Ellwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna</u> <u>P.</u> <u>Doyle</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>November 29</u> <u>19 66</u> Month Day Year				
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>					<b>8. DATE OF BIRTH</b> <u>April 9, 1893</u> <b>9. AGE</b> (In years test birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At home</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					<b>13. FATHER'S NAME</b> <u>Gamiel Hawnie</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Emily J. Leach</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Mrs. Margaret Westcott, 429 N. Ellwood Ave.</u> Address _____					<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) _____					<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____					<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/13, 1966</u> <b>to</b> <u>11/29, 1966</u> <b>that (I) (do) last saw the deceased alive on</b> <u>11/28, 1966</u> <b>and that death occurred at</b> <u>M</u> <b>from the causes and on the date stated above</b>				
<b>22a. SIGNATURE</b> <u>Charles F. O'Donnell</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Charles F. O'Donnell, M.D.</u>					<b>22b. DATE SIGNED</b> <u>12/1/66</u> <b>22d. ADDRESS</b> <u>7501 York Road</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>12.2.66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Moreland Memorial Park</u> <b>23d. LOCATION</b> (City, town or county) <u>Parkville, Md.</u> (State) _____					<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ullrich Funeral Home</u> ADDRESS <u>4210 Belair Road.</u> <b>25a. REC'D BY REGISTRAR</b> <u>DEC 5 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. J. J. J.</u>				

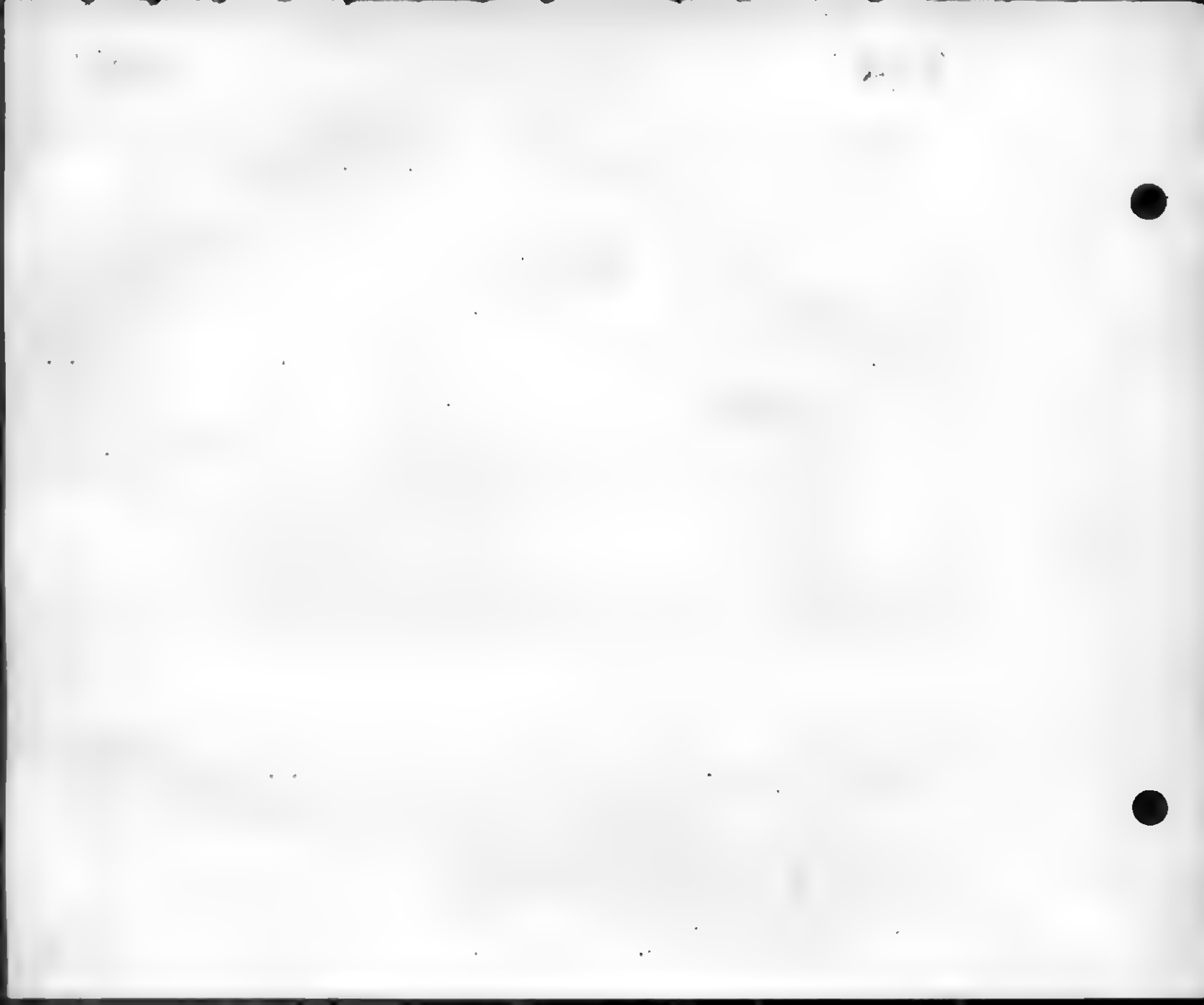


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**15218** **CERTIFICATE OF DEATH** **15216**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>827 61st Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>George Wayne DURNBAUGH</b>				4. DATE OF DEATH <b>11 18 19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-27-57</b>	
9. AGE (In years last birthday) <b>9 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Lenny Durnbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Patricia Joy Ritchie</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe mental retardation</b> <b>Microcephaly, spastic quadriplegia, epilepsy</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>4-15</b> , 19 <b>68</b> , to <b>11-18</b> , 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>11-18</b> , 19 <b>66</b> , and that death occurred at <b>11:35</b> <del>from</del> the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>11/18/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Owings Mills, Md. 21117</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> <b>4308 Suitland Rd. Suitland, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. 2solt Koppanyi  
Rosewood, S - H -



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

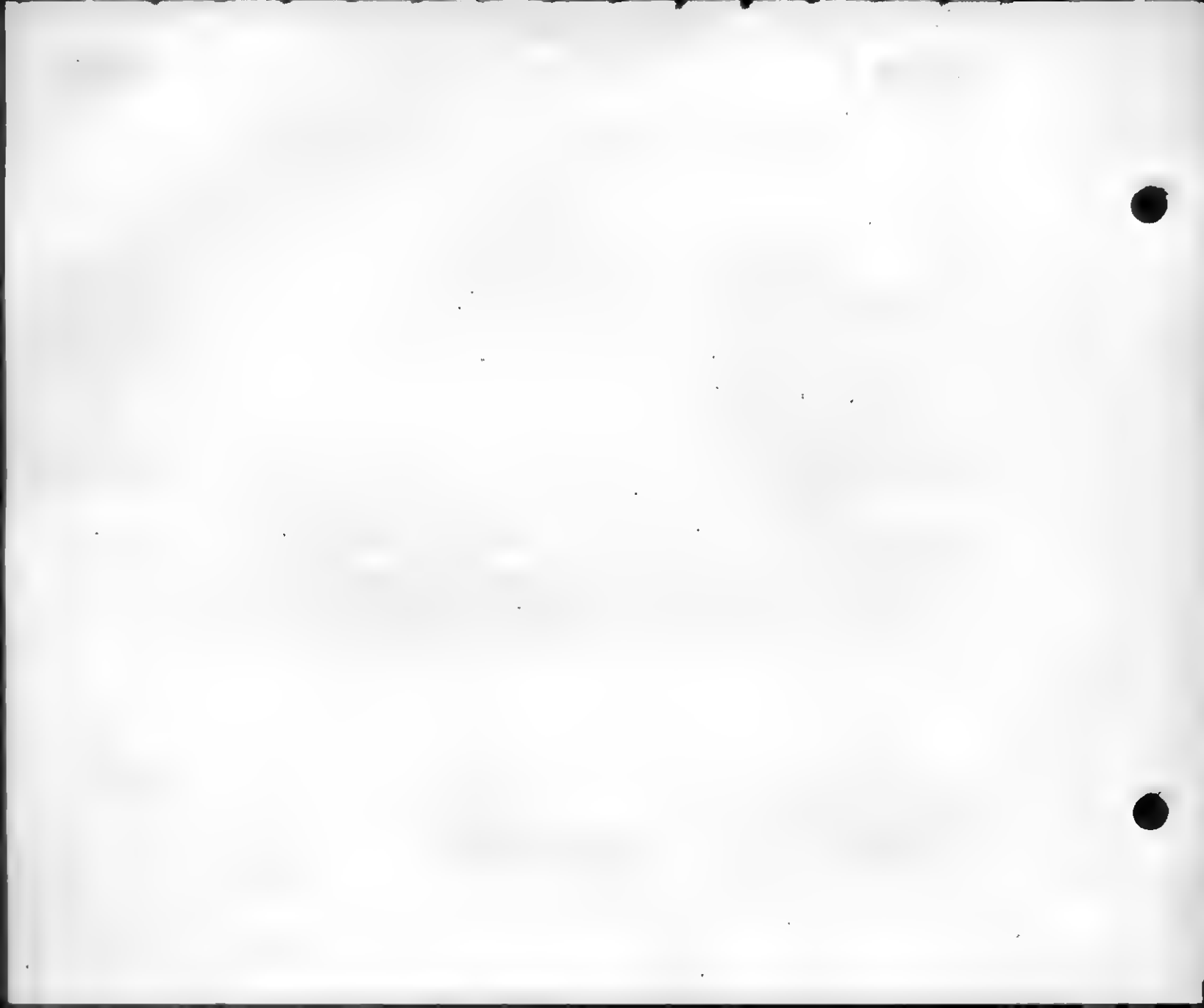
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15219

15217

1. PLACE OF DEATH COUNTY <b>BALTIMORE COUNTY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTO. MEDICAL CENTER 69 HARLTON TRAILER PK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>NEW JERSEY</b> b. COUNTY <b>CHERRY HILL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHERRY HILL</b> d. STREET ADDRESS <b>CHERRY HILL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOROTHY KENT EDENS</b>		4. DATE OF DEATH Month Day Year <b>11 5 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/26</b>
9. AGE (in years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUS GIRL</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEW JERSEY RACE TRACK</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ABINGDON, VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES</b>	
13. FATHER'S NAME <b>HARVEY, CARICO</b>		14. MOTHER'S MAIDEN NAME <b>SNEAD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>227224117</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b> 1051 DUE TO (b) <b>ABDOMINAL CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>CA TRANSVERSE COLON</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 Mos.</b> <b>6 Mos.</b> <b>2 Yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-25-</b> , 19 <b>66</b> , to <b>11-5-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-5-</b> , 19 <b>66</b> , and that death occurred at <b>2:00 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>D. Negrete.</b>		22b. DATE SIGNED <b>11-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DANIEL F. NEGRETE</b>		22d. ADDRESS <b>2909 FALLSTAFF RD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glencoe Cemetery Big Stone Gap, Va.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc Baltimore, Md 21202</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 9 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

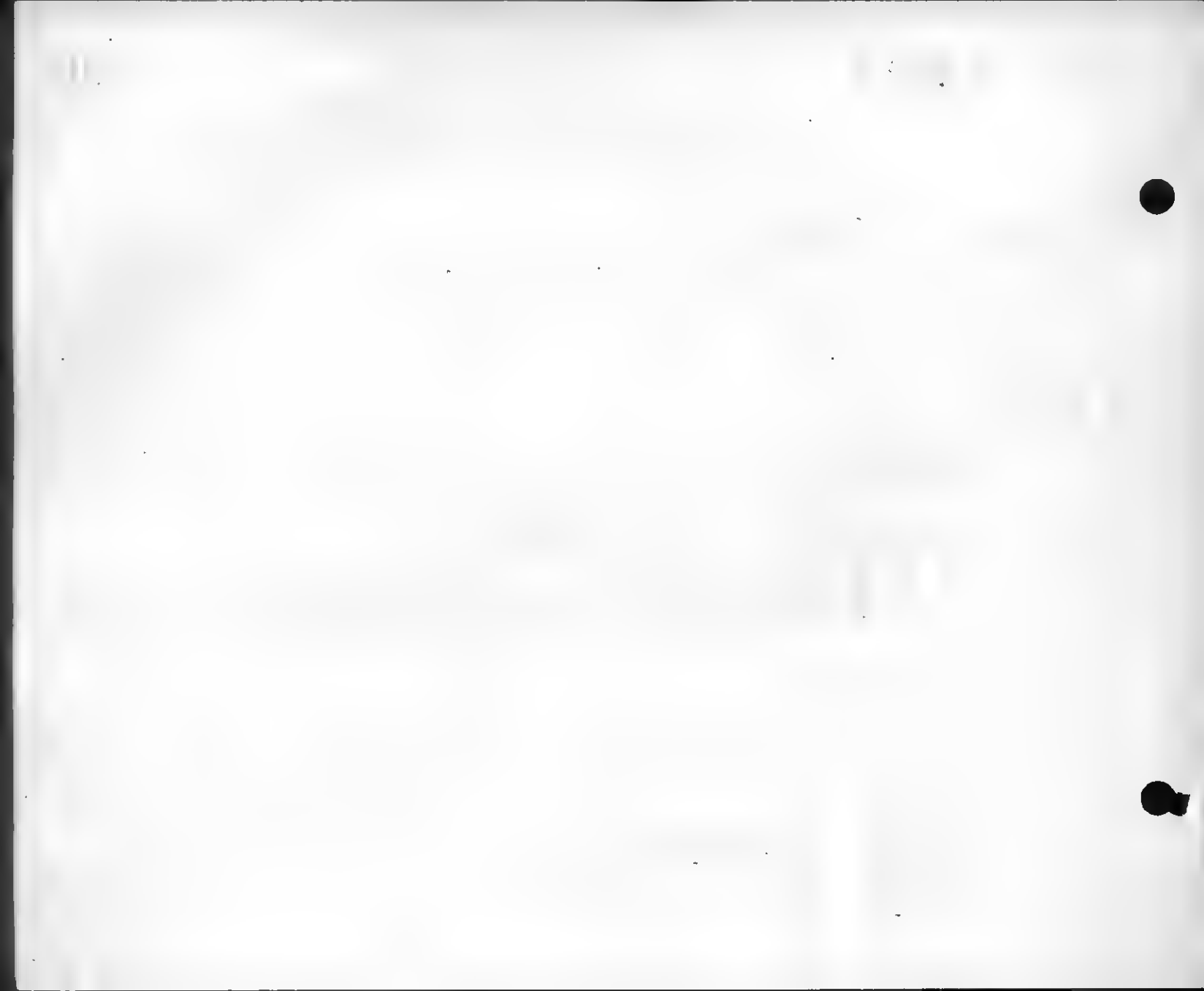
MARYLAND STATE DEPARTMENT OF HEALTH

15220

CERTIFICATE OF DEATH

15218

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La-Nursing Home</b>		d. STREET ADDRESS <b>811 Dorchester Road</b>	
3. NAME OF DECEASED (Type or print) <b>ADOLPH</b> <sup>First</sup> <b>G. Eis, Sr.</b> <sup>Middle</sup> <b>Eis, Sr.</b> <sup>Last</sup>		4. DATE OF DEATH <b>November 29, 1966</b> <sup>Month</sup> <b>29</b> <sup>Day</sup> <b>19</b> <sup>Year</sup>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2- 22- 1879</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-05-3543A</b>	
17. INFORMANT <b>Mrs. Amelia D. Eis, 811 Dorchester Rd. Md.</b>		Address <b>21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>422.1</b> IMMEDIATE CAUSE (a) <b>CUA</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>?</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 Wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 19, 1966</b> to <b>Nov 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>11-29</b> 1966, and that death occurred at <b>10:30</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Frank Pass</b>		22b. DATE SIGNED <b>11-29-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEDEL PASS</b>		22d. ADDRESS <b>1001 Wilkens Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-1-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>3801 Frederick Ave. Md. 21229</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15221					15219				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>					d. STREET ADDRESS <u>5317 Nelson Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Ellerin</u>			First Middle Last		4. DATE OF DEATH <u>November 15,</u> 19 <u>66</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mr. Charles Ellerin, 3604 Woodvalley Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> DUE TO (b) <u>H A S K I D</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>107 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> , 19 <u>46</u> , to <u>11/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>66</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Israel Zinberg</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/16/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Israel Zinberg</u>					22d. ADDRESS <u>4000 NOTHERN PARKWAY</u>				
23a. BURIAL (Specify)		23b. DATE THEREOF <u>11/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nesina</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>					25a. REC'D BY REGISTRAR <u>NOV 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1921

1921



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15222

CERTIFICATE OF DEATH

15220

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e. STREET ADDRESS <b>2461 Ellis Rd. 5608 Birchwood Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>John</b> Last <b>ENGELBACH, Jr</b>				4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1881</b>	
9. AGE (In years last birthday) <b>85</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>George Engelbach</b>			
14. MOTHER'S MAIDEN NAME <b>Anna</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO <b>216053280A</b>				17. INFORMANT <b>William J. Engelbach, Jr. 2461 Ellis Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of prostate with multiple metastases.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/8/</b> , 19 <b>66</b> , to <b>11/8/</b> , 1966, that (I) (we) last saw the deceased alive on <b>11/8/</b> , 19 <b>66</b> , and that death occurred at <b>1:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>M.S. Cockburn, M.D.</b>				22b. DATE SIGNED <b>11/8/66</b>		22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>				22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>				25. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15221

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first tuition Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Berk</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rural - Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 316, Beyer Hill Rd.</u>		e. STREET ADDRESS <u>1422 Linden St.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Grace Esther Englehart</u>		4 DATE OF DEATH Month Day Year <u>11 - 26 1966</u>	
5 SEX <u>Female</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-22-1904</u>
9 AGE (In years last birthday) <u>62</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11 BIRTHPLACE (State or foreign country) <u>Reading, Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar B. Heim</u>		14 MOTHER'S MAIDEN NAME <u>Sarah Titlow</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>170-22-0624</u>	
17 INFORMANT <u>Jean Ellen Reinhart, Box 316, Cockeysville, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO <u>2+7</u> (c) <u>General Vascular Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>		22. DATE SIGNED <u>11/26/66</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11/26/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <u>Reading, Pa.</u>	
24. FUNERAL DIRECTOR <u>Wm. T. Tice, Sons of Mt. Ball Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15224

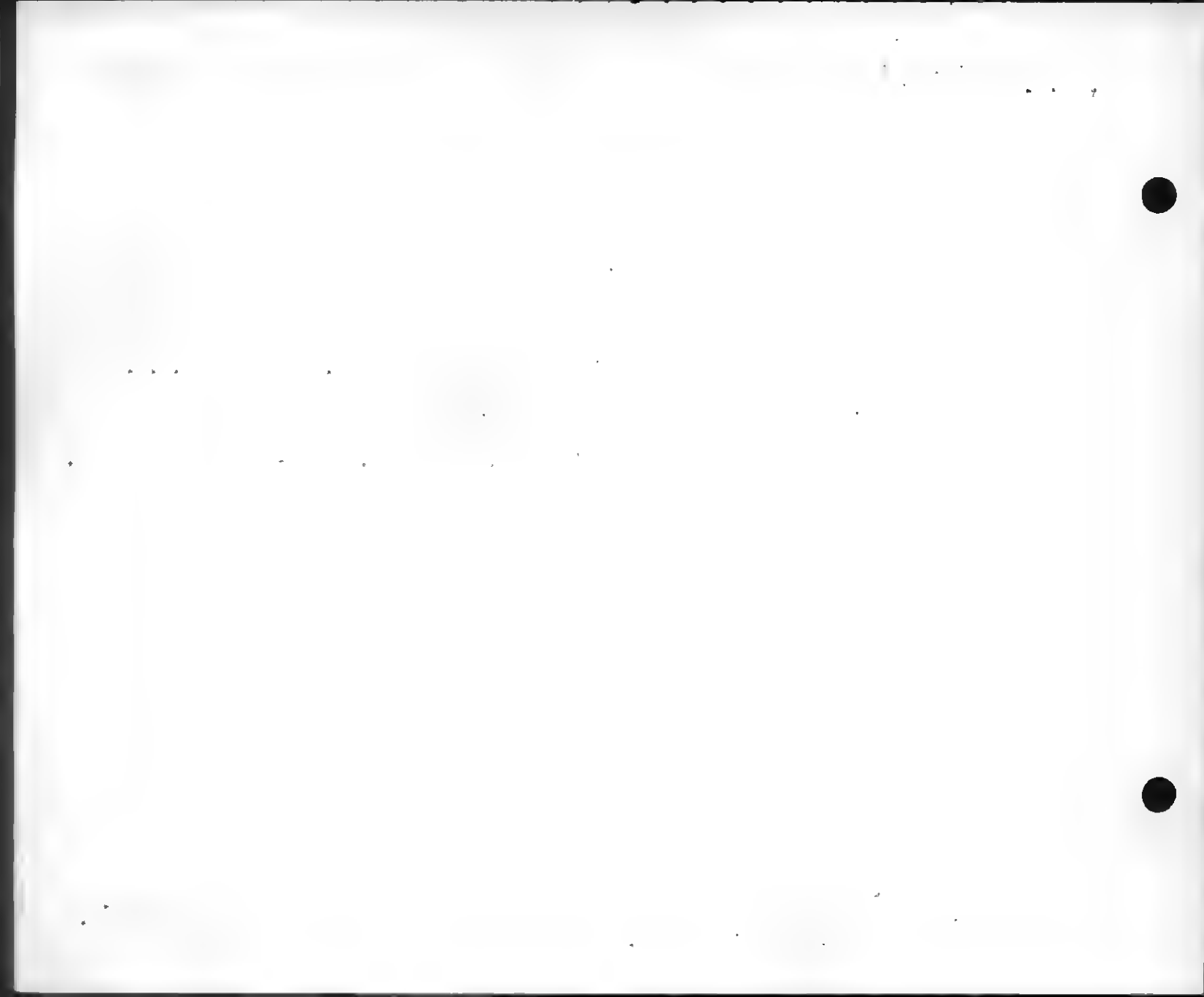
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15222

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d STREET ADDRESS <b>3001 Virginia Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B.</b> Last <b>EVANS</b>		4 DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/30/1894</b>
9 AGE (In years last birthday) <b>72 yrs</b>		10 IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min <b>72</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11 BIRTHPLACE (State or foreign country) <b>Moosic, Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John Jenkins</b>		14 MOTHER'S MARDEN NAME <b>Jennie Mae Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>217-05-8307</b>	
17. INFORMANT <b>Mrs. Lillian E. Evans-3001 Virginia Ave.</b>		Address <b>21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Spinal Cord Contusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture of Odontoid Process.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell from scaffold.</b>	
20c TIME OF INJURY Hour <b>2:45</b> p.m. Month, Day, Year <b>11/3 1966</b>		20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House</b>		20f (City or town) (County) (State) <b>Cockeysville Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>11/4/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/7/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		23d LOCATION (City or Town) (County) (State) <b>Nash, Blvd. &amp; Dorsey Rd. Balt. Md.</b>	
24 FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown</b>		25a REC'D BY REGISTRAR DATE <b>NOV 7 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15225

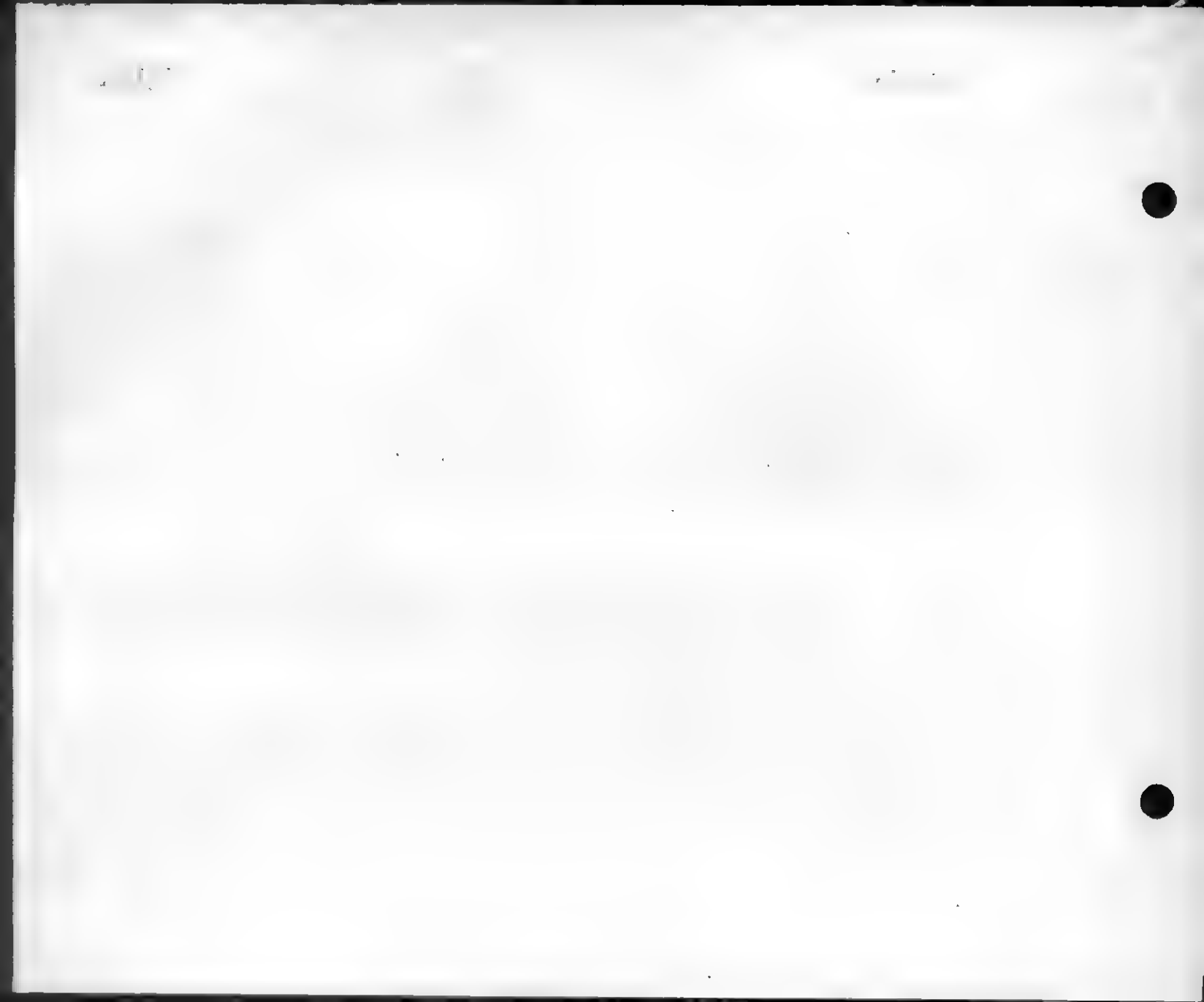
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15223

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> <u>Towson</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY in lb <u>10 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		d. STREET ADDRESS <u>3413 Orbiter Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>T.</u> Last <u>Ewing</u>		4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1916</u>
9. AGE (In years last birthday) <u>50 yrs</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during past 12 months, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lipman Elec. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Golden F. Ewing</u>		14. MOTHER'S MAIDEN NAME <u>Anna Belle Gardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>26-01-744</u>	
17. INFORMANT <u>Helen M. Ewing</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c) <u>Interval between onset and death</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 1 of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>		22. DATE SIGNED <u>11/25/66</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-29-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Md</u>
24. FUNERAL DIRECTOR <u>Chas. F. Evans &amp; Son</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1966</u>	
ADDRESS <u>8802 Harford Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15226

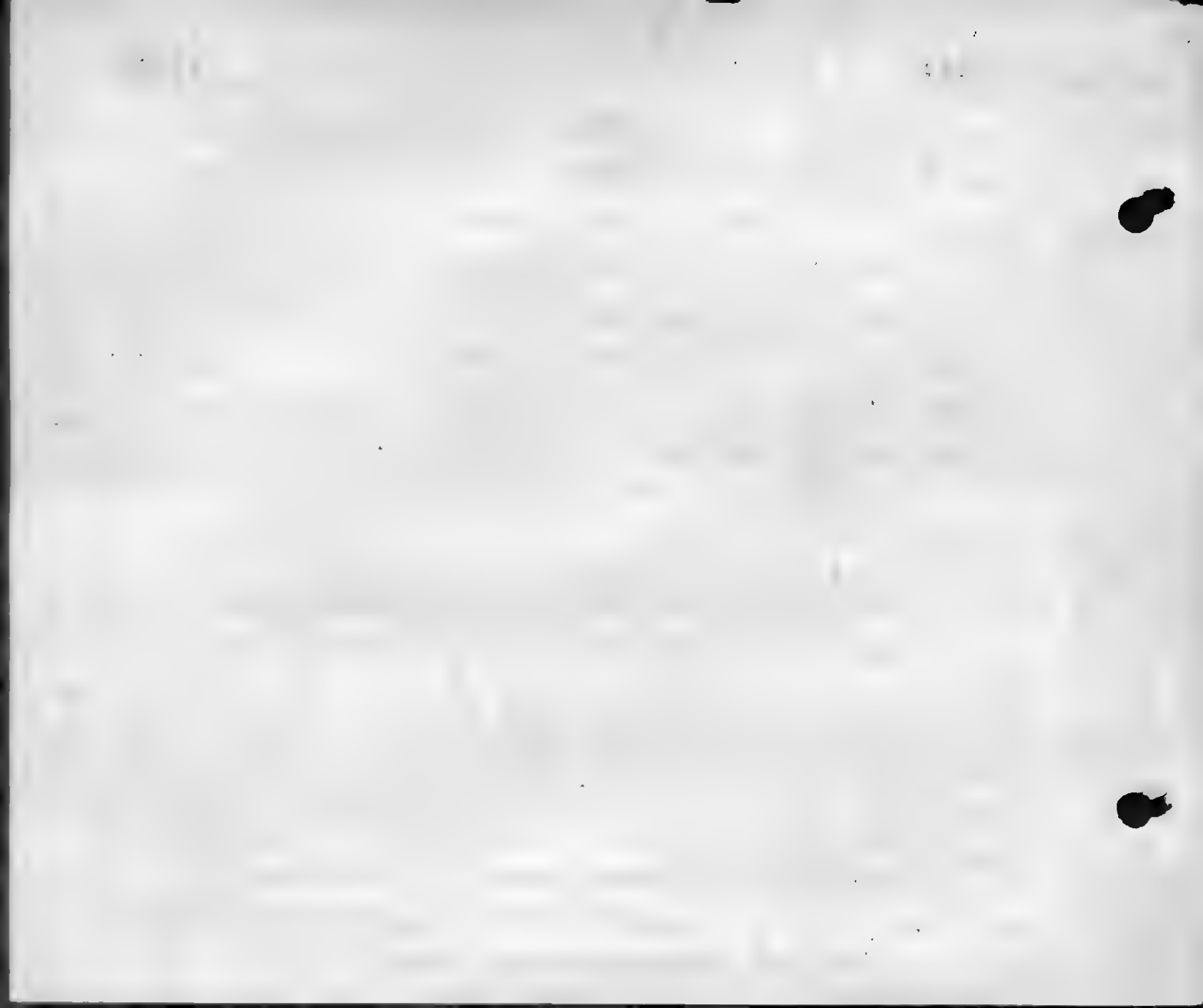
## CERTIFICATE OF DEATH

15224

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kentland</b> d. STREET ADDRESS <b>7640 Greely Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Allison James Ezzell</b>		4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1966</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7.10.24</b>		9. AGE (in years last birthday) <b>42</b> yrs.		10. UNOER 1 YEAR <input type="checkbox"/> UNOER 24 HRS. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>				11. BIRTHPLACE (County & State, or foreign country) <b>N Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Victor Ezzell</b>								14. MOTHER'S MAIDEN NAME <b>Greece Rackley</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>W.W.I.</b>				16. SOCIAL SECURITY NO. <b>241-30-7109</b>				17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> <b>CO21</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>												INTERVAL BETWEEN ONSET AND DEATH <b>8 wks.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>11.4.1966</b> to <b>11.14.1966</b> , that (I) (we) last saw the deceased alive on <b>11.14.1966</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Wm. Newcomer</b>												22b. DATE SIGNED <b>11.14.66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>												22d. ADDRESS <b>Mount Wilson, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11.18.66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem Arlington Virginia</b>				23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300.4th st N E</b>												25a. REC'D BY REGISTRAR <b>NOV 18 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			







FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

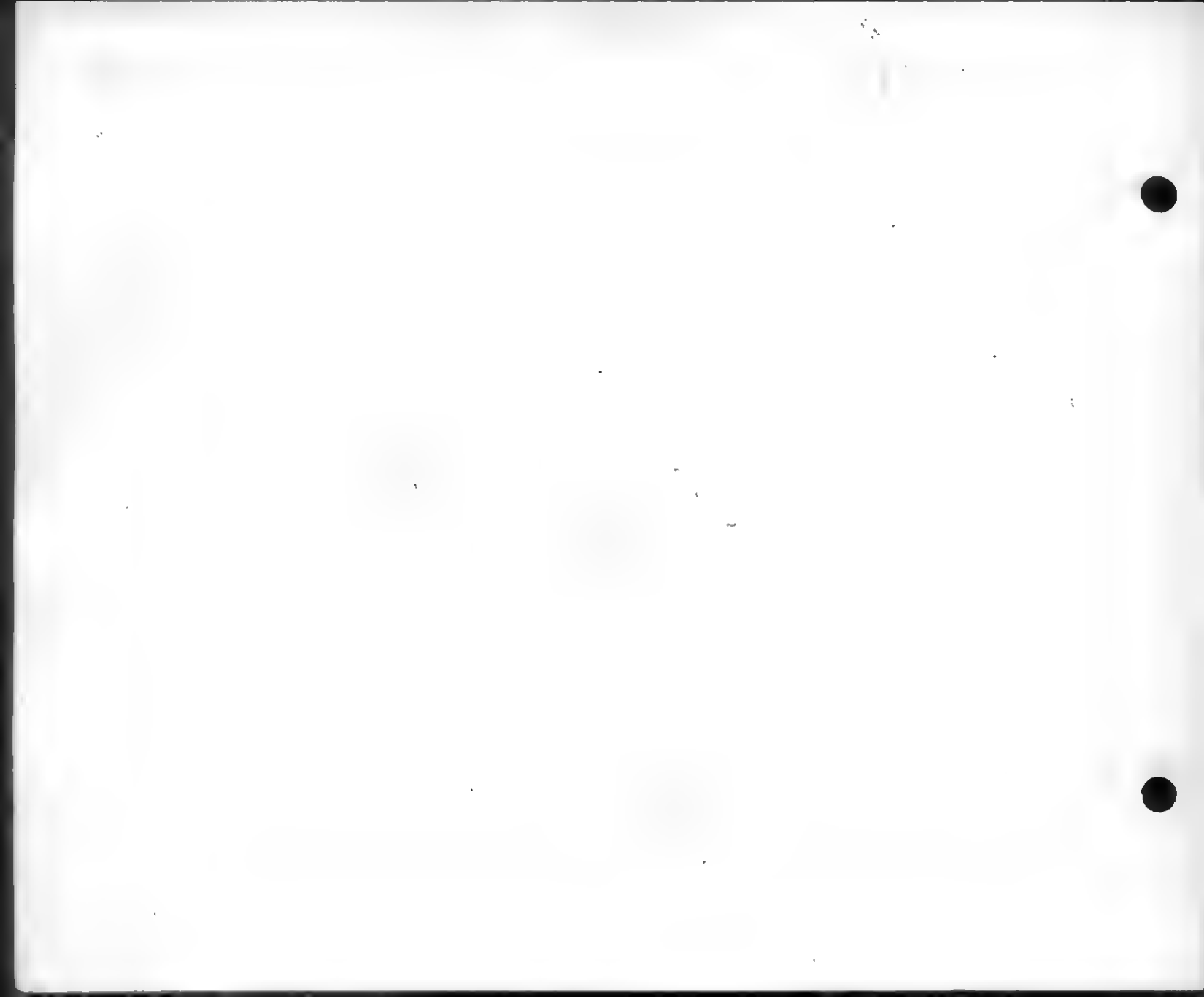
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15228

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15226

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Louison</u>		c LENGTH OF STAY in 1b <u>Parkville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d STREET ADDRESS <u>7933 Highpoint Road</u>	
3 NAME OF DECEASED (Type or print) <u>Carmelo</u> First <u>fazio</u> Middle Last		4 DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>19 66</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-25-1893</u>
9 AGE (In years last birthday) <u>73</u> YRS		10 IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11 BIRTHPLACE (State or foreign country) <u>Italy</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Joseph fazio</u>		14. MOTHER'S MAIDEN NAME <u>Santina Riveda</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WWI</u>		16 SOCIAL SECURITY NO <u>same</u>	
17 INFORMANT <u>Rose Fazio</u> Address <u>same</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>6 Cor Pulmonale</u> DUE TO <u>Chronic Nephritis</u> (c) <u>Chronic Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		22. DATE SIGNED <u>11/16/66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>11-19-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health as its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15229

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15227

1 PLACE OF DEATH a CO. NTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Balto.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Maryland</b>		c LENGTH OF STAY IN 1b <b>30-4</b> 21212	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>		d STREET ADDRESS <b>6223 Northwood Dr.</b> <b>ST. JOSEPH DRIVE</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JENNIE A. FERSTERMAN</b>		4. DATE OF DEATH Month Day Year <b>Nov. 7th. 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1892</b>
9 AGE (in years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>American Bakery</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>John Paul</b>		14 MOTHER'S MAIDEN NAME <b>Mary Einwich</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16 SOCIAL SECURITY NO. <b>213-03-6699A</b>	
17 INFORMANT Address <b>Mrs. Doris M. Hutten-6223 Northwood Dr.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Natural Causes</b> and (b), if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Complications of Lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>11/7/66</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/11/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>
23d LOCATION (City or Town) <b>Balto.</b>		(County) (State)	
24 FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Road-21212</b>		25a REC'D BY REG STRAR DATE <b>NOV 9 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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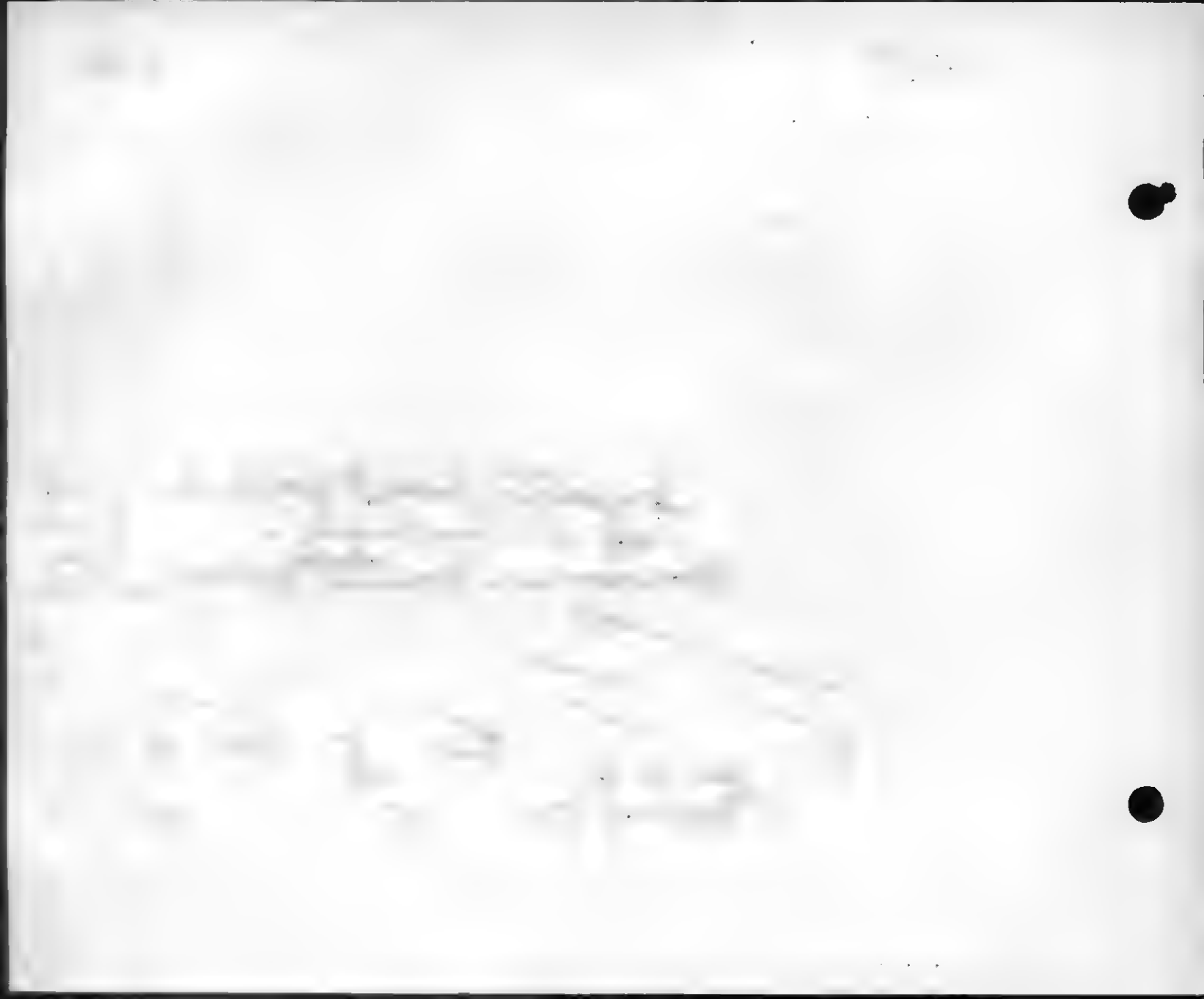
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15230 CERTIFICATE OF DEATH 15225

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9614 Harding ave</b>				d. STREET ADDRESS <b>9614 Harding ave</b>			
3. NAME OF DECEASED (Type or print) <b>STEPHEN J FERTITTA</b>				4. DATE OF DEATH <b>November 23 1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1 1911</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rec Dept</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Salvatore Fertitta</b>				14. MOTHER'S MAIDEN NAME <b>Frances Conoscenti</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1 215-10-0281</b>		17. INFORMANT <b>Family records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>15-21 Congestive Heart Failure</b> DUE TO (b) <b>Chronic Pulmonary</b> DUE TO (c) <b>Bronchogenic Carcinoma Right Left lung metastasis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8-10 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Mar 1966</b> to <b>Nov 1966</b> , that (1) (we) last saw the deceased alive on <b>Nov 23 1966</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank Kasik</b>				22b. DATE SIGNED <b>11/25/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Frank Kasik</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>9005 Harford road</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>				25a. REC'D BY REGISTRAR <b>NOV 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completed and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health.

# MARYLAND STATE DEPARTMENT OF HEALTH

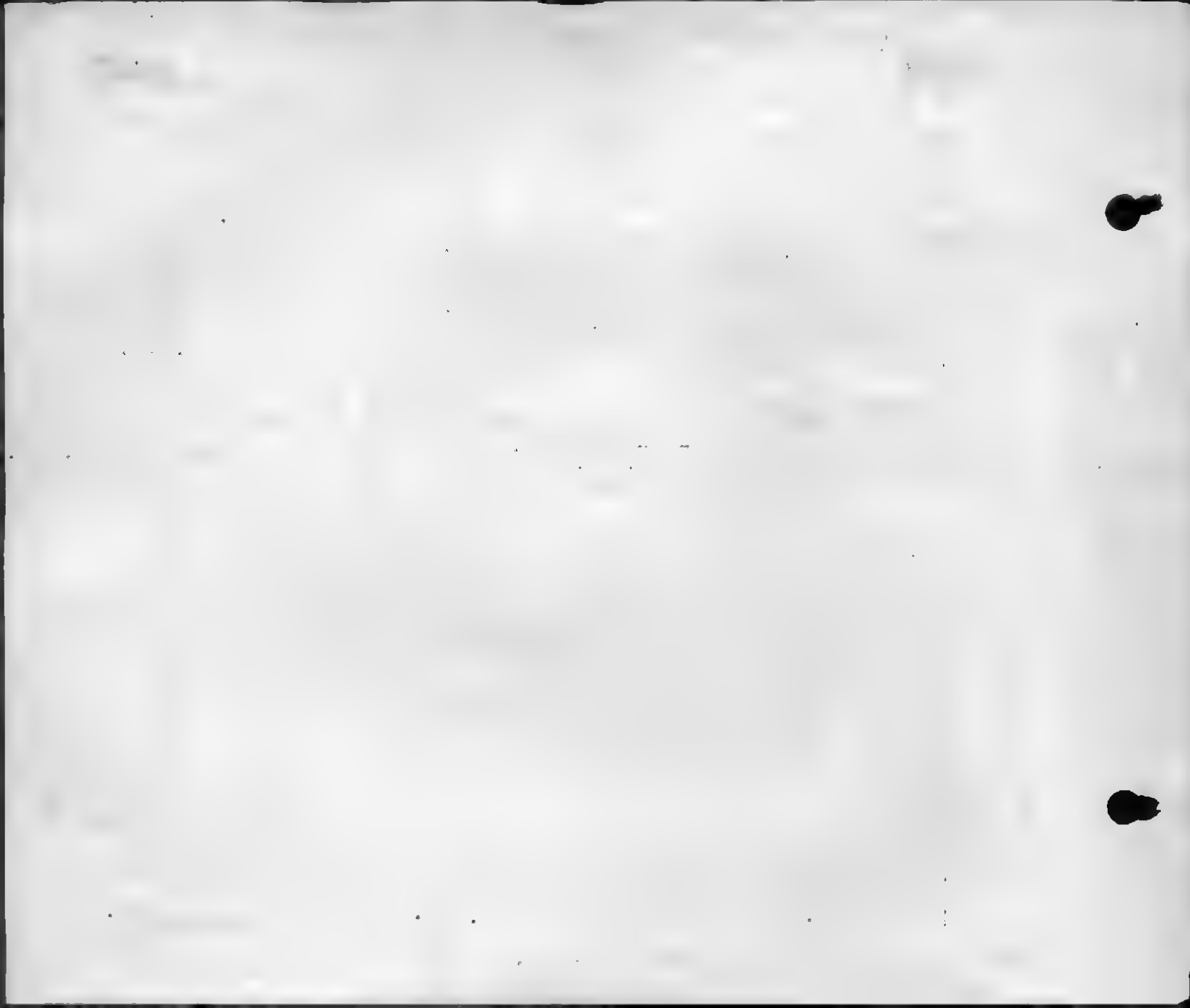
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15231

15229

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Peisterstown</u> c. LENGTH OF STAY IN b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>958 Shirley Manor Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>958 Shirley Manor Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Patrick Joseph Fiori</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Nov. 22 19 66</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 12, 1893</u>
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>10. AGE</b> (In years last birthday) <u>73</u> yrs.	<b>11. AGE</b> (In years last birthday) <u>73</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>State of Maryland</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Jersey</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Fiori</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-36-0628</u>	
<b>17. INFORMANT</b> <u>Mrs. Ruth B. Fiori</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure</u> DUE TO (b) <u>Dehydration &amp; Malnutrition</u> DUE TO (c) <u>Cerebral Vascular Accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced arteriosclerosis</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. TIME OF INJURY</b> Month, Day, Year <u>June 19 66</u> to <u>11/22 19 66</u>	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from June 19 66 to 11/22 19 66 that (I) (we) last saw the deceased alive on 11/22 19 66, and that death occurred at 3:30 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>William J. Bryson</u> M.D.		<b>22b. DATE SIGNED</b> <u>11/22/66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>William J. BRYSON</u>		<b>22d. ADDRESS</b> <u>4605 Edmondson Ave</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov. 24, 1966</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Old Oakland Ch. Cem.</u>		<b>23d. LOCATION</b> (City, town or County) (State) <u>Sykesville Maryland.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. J. Eckhardt</u>		<b>24b. ADDRESS</b> <u>Owings Mills, Md.</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>NOV 25 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. [illegible]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

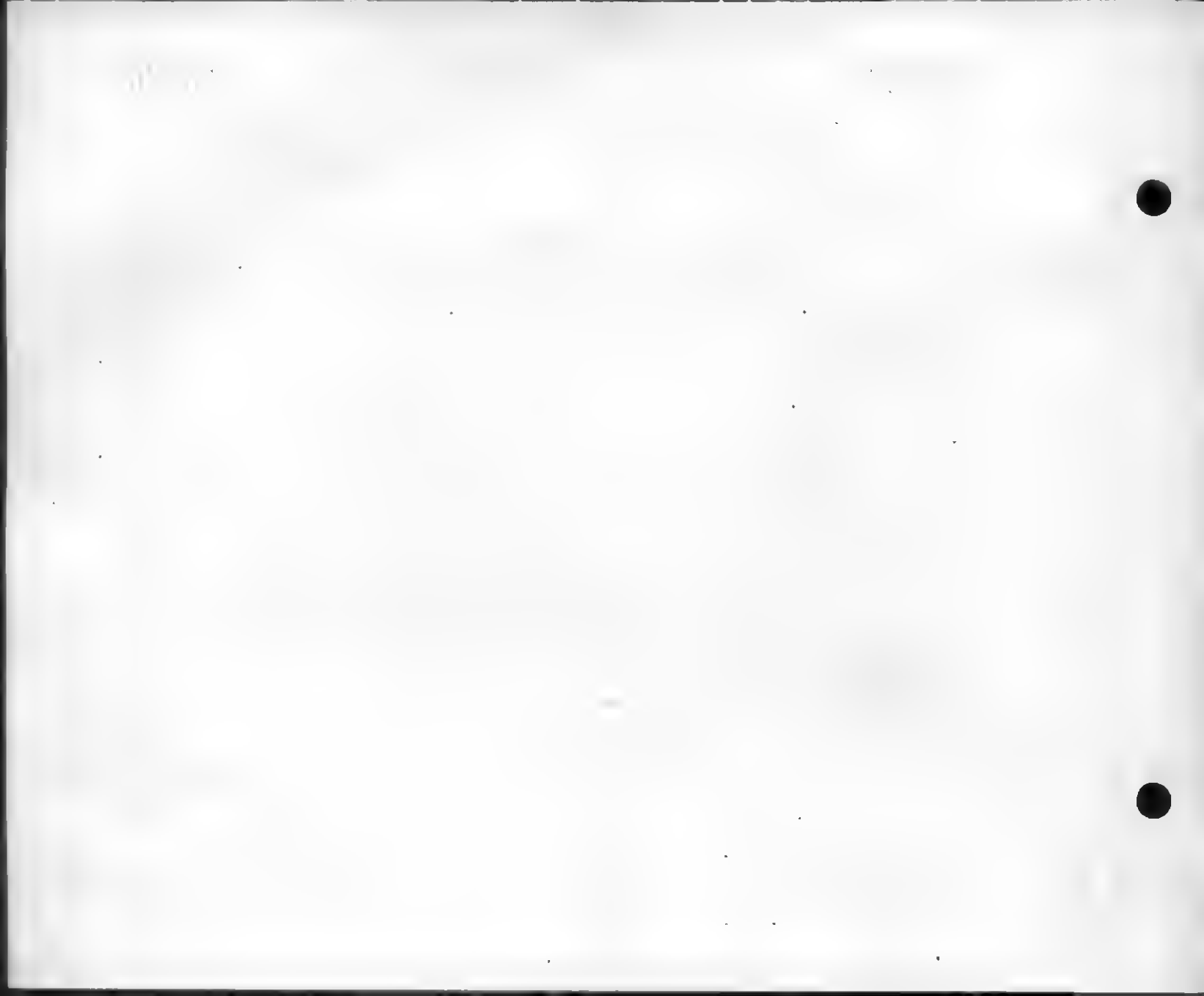
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15232

15230

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN 1b <b>10 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 151 Church Lane</b>		d. STREET ADDRESS <b>Box 151 Church Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Hilda</b> Middle <b>Benson</b> Last <b>Ford</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1910</b>
9. AGE (In years last birthday) <b>55 yrs</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> M.n.	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cockeysville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William W. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Nannie Howard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Ellsworth S. Ford, Cockeysville, Md. 21030</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b> <b>3 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>AUG.</b> , 1964, to <b>NOV. 20</b> , 1966, that (I) (we) last saw the deceased alive on <b>NOV. 16</b> 1966, and that death occurred at <b>12:00</b> A.M., from causes and on the date stated above.			
22a. SIGNATURE <b>William A. Pillsbury</b>		22b. DATE SIGNED <b>11-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>		22d. ADDRESS <b>Timonium, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 23, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

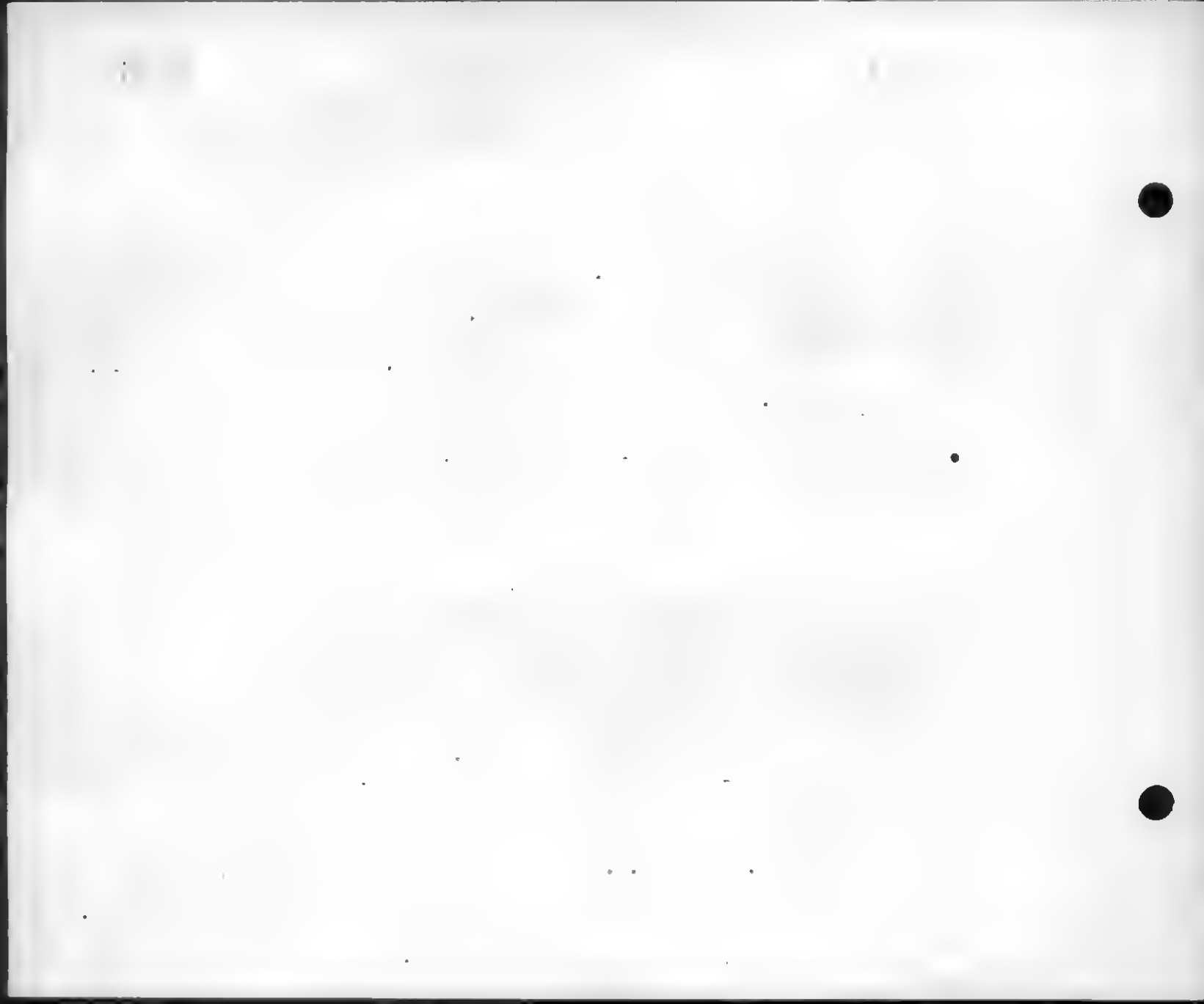
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15233

# CERTIFICATE OF DEATH

15231

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c LENGTH OF STAY IN 1b <b>1 yr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Cecil County</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> d STREET ADDRESS <b>Radio Avenue</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>WILBUR E. FORD</b>		4 DATE OF DEATH Month <b>11</b> Day <b>25</b> Year <b>66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1874 Nov. 24 1873</b>
9 AGE (In years and months) <b>93 92</b>		10 UNDER 1 YEAR Months <b>11</b> Days <b>25</b> Hours <b>00</b> Min <b>00</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Cecil Co. Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John F. Ford</b>		14 MOTHER'S MAIDEN NAME <b>unknown Mary F. Miller</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>215-22-8201</b>	
17 INFORMANT <b>RECORDS: Spring Grove State Hospital</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction - acute</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular heart disease</b> DUE TO (c) <b>Arteriosclerosis - generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 23, 1966</b> , to <b>November 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>11-25-1966</b> , and that death occurred at <b>1:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED <b>11-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>		23d. LOCATION (City or Town) (County) (State) <b>North East Cecil Md.</b>	
24. FUNERAL DIRECTOR <i>Gail H. Hough</i>		25a. REC'D BY REGISTRAR <b>NOV 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			



1  
FOR STATE  
HEALTH DEPT.

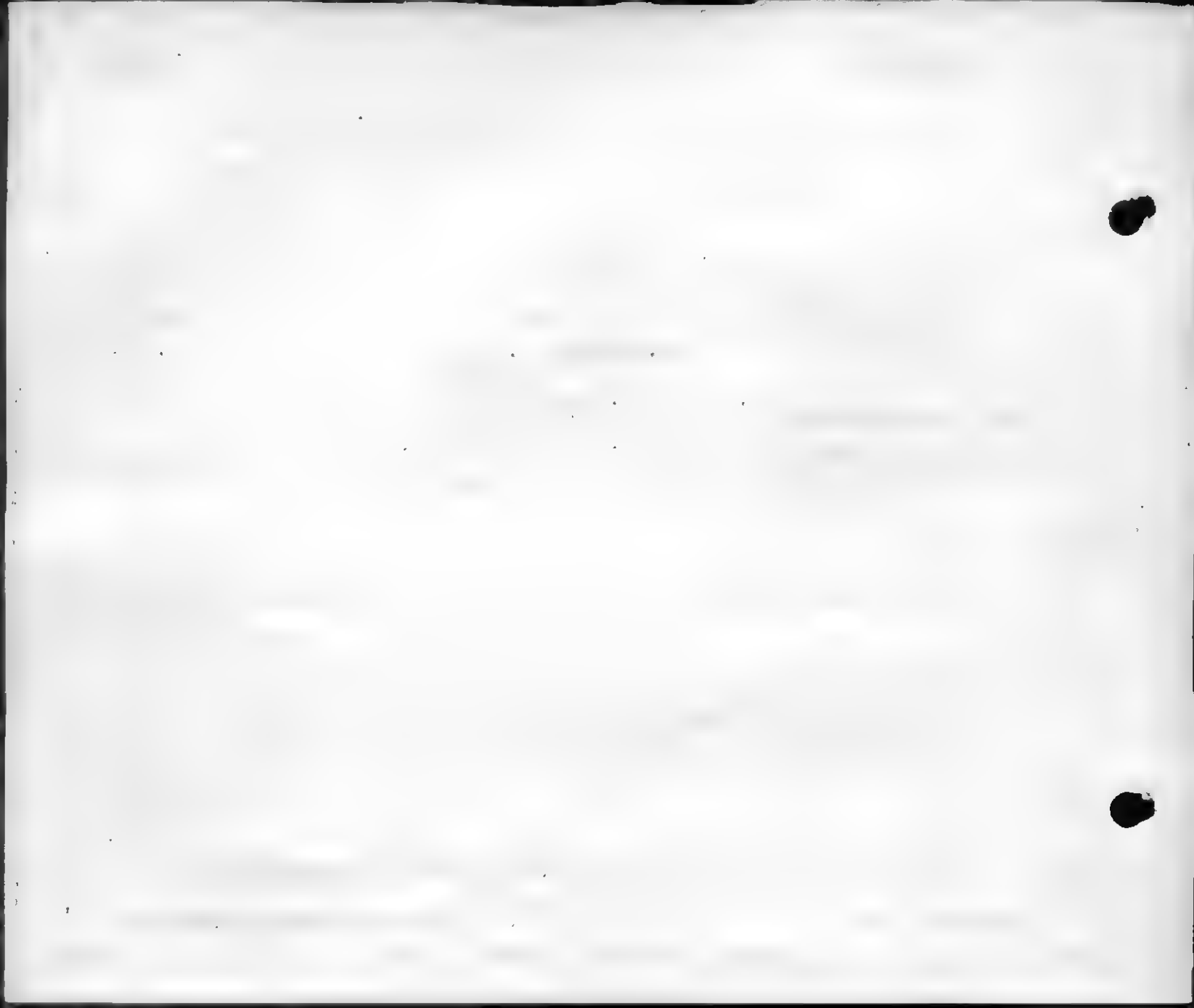
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

15234

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15232

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
c. LENGTH OF STAY IN 1b <u>25 yrs</u>		d. STREET ADDRESS <u>1003 Race Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1003 Race Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Cleveland</u> Last <u>Frank Jr.</u>		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1909</u>
9. AGE (In years last birthday) <u>57 yrs.</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>30</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fred. Obrecht Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Grover C. Frank Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Schanclara</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>216-10-7883 Mr Joseph W. Frank 1003 Race Road 21221</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (a), stating the underlying cause last. (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/1/66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Lorraine Funeral Home 7481 Belair Road</u>		ADDRESS <u>34</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 2 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

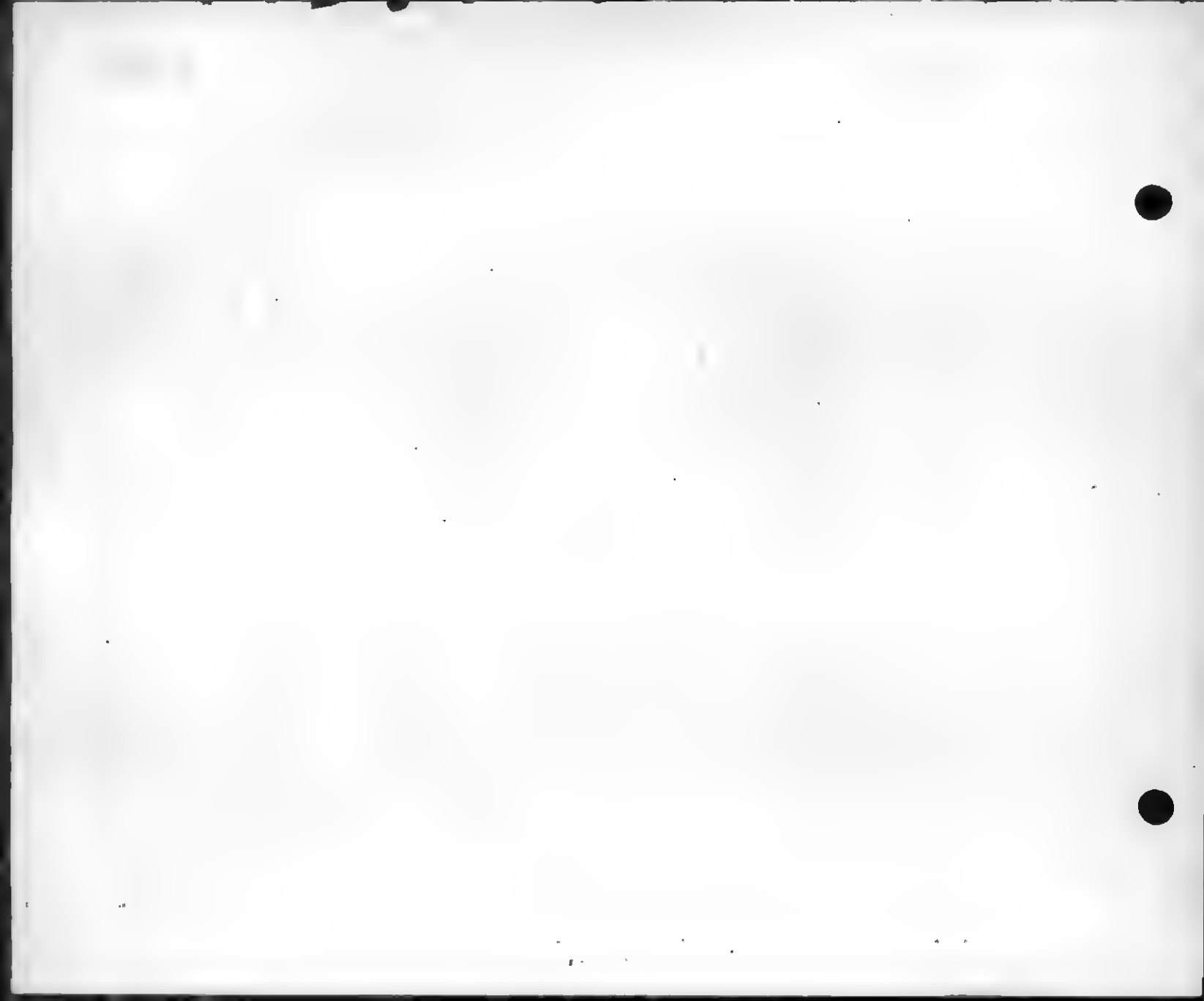
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15235

15233

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO. MD.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANN ELIZABETH FREEMAN</b>		4. DATE OF DEATH Month <b>11</b> - Day <b>14</b> - Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>CAY</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-27</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9c. AGE (In years last birthday) <b>38 yrs.</b>
10a. BIRTHPLACE (County & State, or foreign country) <b>BALTO. MD.</b>		10b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. FATHER'S NAME <b>JOHN R. DILWORTH</b>		12. MOTHER'S MAIDEN NAME <b>ETHEL MARY SHAW</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		14. SOCIAL SECURITY NO. <b>PT. CHART</b>	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DISSEMINATED LUPUS</b> DUE TO (b) <b>ERYTHEMA TOSIS -</b> DUE TO (c) <b>ERYTHEMA TOSIS -</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-11-66</b> , 19 <b>66</b> , to <b>11-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-14-1966</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>D. Kuwilsky</b>		22b. DATE SIGNED <b>11-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dora C. Kuwilsky</b>		22d. ADDRESS <b>Greater Baltimore Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/18/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d. LOCATION (City, town or county) (State) <b>Parkville, Balto. Co., Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 16 1966</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

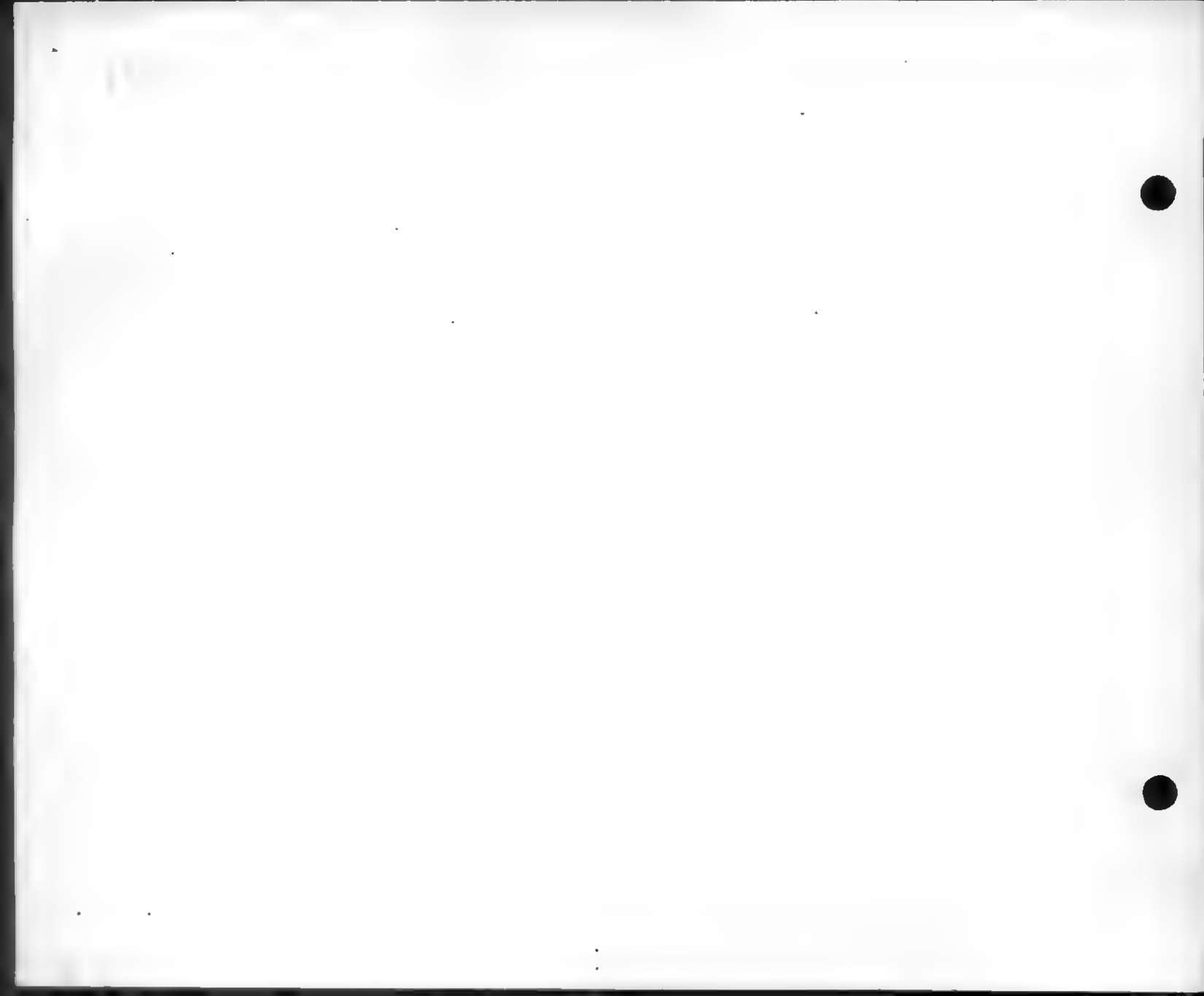
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film 3382 11/14/66 mh

15236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15234

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> Baltimore 12	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSP</b>		d STREET ADDRESS <b>617 Beaumont Ave.</b> <b>PROTESTANT HOME</b>	
3 NAME OF DECEASED (Type or print) First <b>VIOLET</b> Middle <b>FULD</b> Last <b>FULD</b>		4 DATE OF DEATH <b>NOVEMBER 4</b> 19 <b>66</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/21/29</b>
9 AGE (In years last birthday) <b>37</b>		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>Jacob Fuld</b>		14 MOTHER'S MAIDEN NAME <b>Mary Abel</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>CHART AT SPRING GROVE HOSP.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO <b>2) HSCVD</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>3) DIABETES MELLITUS</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5/31/66</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRacture OF LEFT FEMUR</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>FELL OUT OF BED</b>	
20c TIME OF INJURY Month, Day, Year <b>11/4/66 10/11 1966</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>SPRING GROVE HOSP</b>		20f (City or town) (County) (State) <b>CATONSVILLE BALTO MD</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edmund Kerasi</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. KASAITIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>11/4/66</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11-7-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d LOCATION (City or Town) (County) (State) <b>Anne Arundel Co., Md.</b>
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b> <b>6500 York Road Baltimore, Md. 21212</b>		25a REC'D BY REGISTRAR <b>NOV 7 1966</b>	
25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

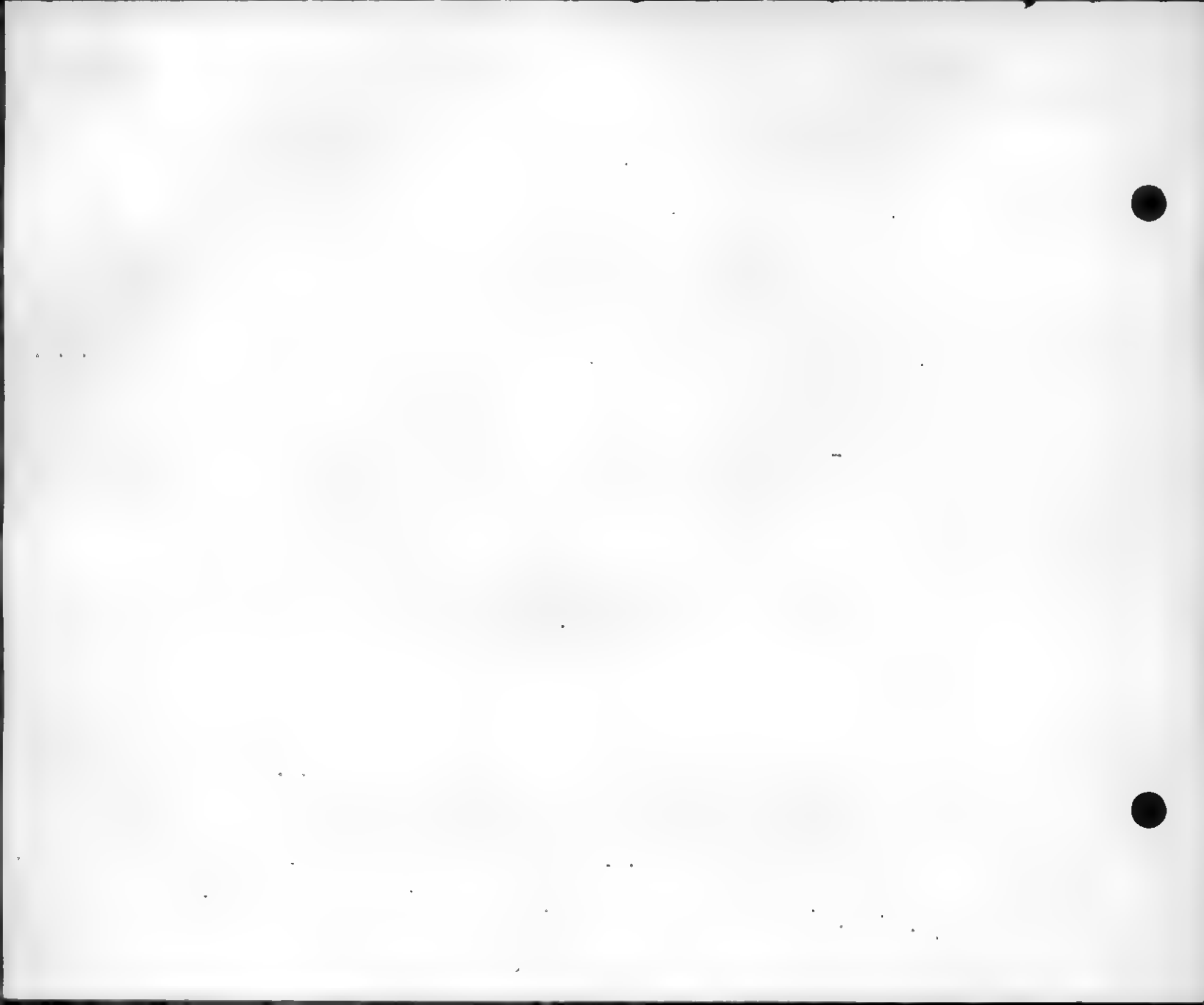




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15237					15235				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM?									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
5. SEX					6. COLOR OR RACE				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					8. DATE OF BIRTH				
9. AGE (In years last birthday)					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO <u>Shigellosis?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tetralogy of Fallot (op.)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11-7</u> , 19 <u>66</u> to <u>11-21</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11-21</u> , 19 <u>66</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.					22b. DATE SIGNED				
22a. SIGNATURE <u>Zsolt Koppanyi</u>					22c. PHYSICIAN'S NAME (Type) <u>Zsolt Koppanyi, M.D.</u>				
22d. ADDRESS <u>Rosewood State Hospital, Owings Mill Md.</u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
25b. REGISTRAR'S SIGNATURE					DATE				



TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15238

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15236

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY in 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holliday Inn</b>		e. STREET ADDRESS <b>1128 Jamestown Cressent</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Leonard Meredith Galbraith</b>		4 DATE OF DEATH Month Day Year <b>Nov. 13, 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-31-1906</b>
9. AGE (in years last birthday) yrs <b>60</b>		10. IF UNDER 1 YEAR Months Days <b>60</b>	11. IF UNDER 24 HRS. Hours Min <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surgeon</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	
11. BIRTHPLACE (State or foreign country) <b>Richmond, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aubrey H. Galbraith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Newby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>229-03-3655</b>	
17. INFORMANT <b>Mrs. Mary Roberta Galbraith, 1128 Jamestown Cressent, Norfolk 8, Va.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> F J C I DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b> EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		22. DATE SIGNED <b>11-14-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 16, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forrest Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Norfolk Va.</b>	
24. FUNERAL DIRECTOR <b>Frank H. Newell, Pikesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1/2

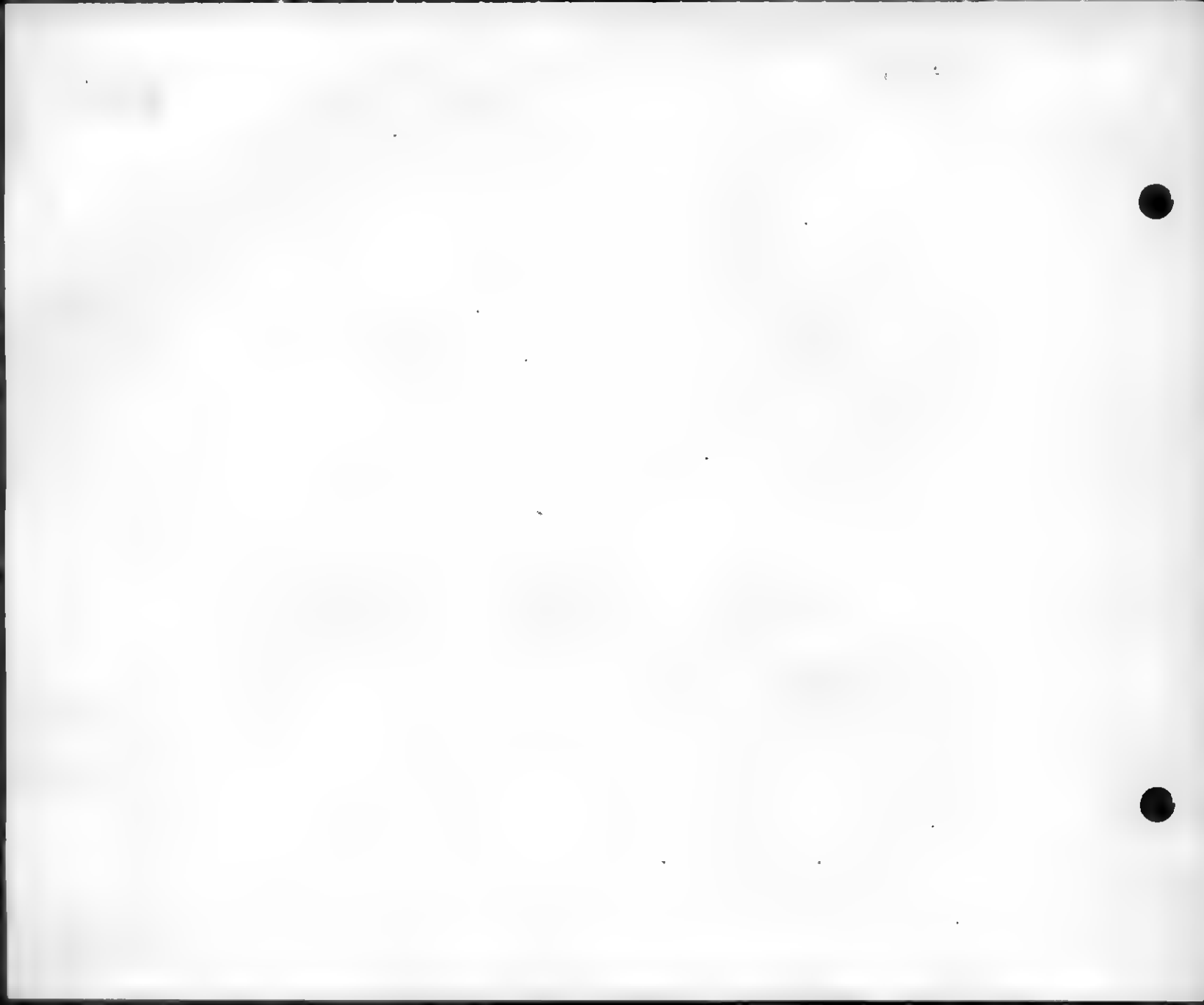
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 23c, 23d Film G383 11/25/66

15239

CERTIFICATE OF DEATH

15237

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>21206</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2330 Hamiltowne Circle</b>		e. STREET ADDRESS <b>2330 Hamiltowne Circle</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>BERNARD JOHN GAPHARDT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/1920</b>
9. AGE (In years last birthday) <b>46</b> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <b>4</b> Days <b>15</b> Hours <b>19</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lithographer - Crown Cork &amp; Seal Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Sylvester Gaphardt</b>		14. MOTHER'S MAIDEN NAME <b>Anna Jarousek</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-2506</b>	
17. INFORMANT <b>Helen Zavodny Gaphardt, wife, above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> 1492 DUE TO (b) <b>Generalized Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>4 days</b> <b>4 months</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/3</b> , 1966, to <b>8/15</b> , 1966, that (I) (we) last saw the deceased alive on <b>11/3</b> , 1966, and that death occurred at <b>6:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Isadore K. Grossman</b> M.D.		22b. DATE SIGNED <b>11/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Isadore K. Grossman</b>		22d. ADDRESS <b>1527 E. North Avenue</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>4430 Belair Rd., Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schirumek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>NOV 18 1966</b>	
25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 retained by the hospital or attending physician. Page 2 retained by the funeral home. Page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

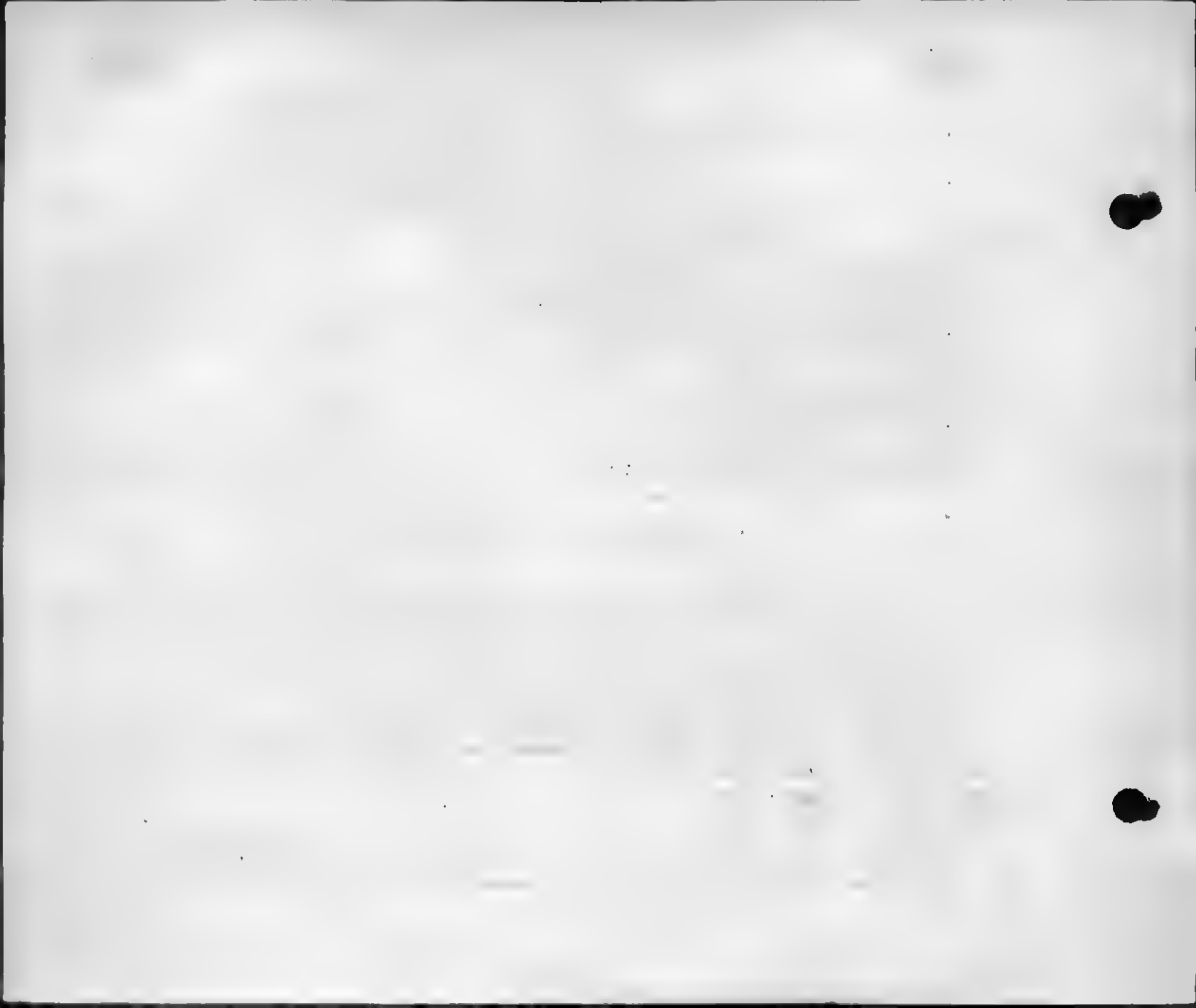
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15240

## CERTIFICATE OF DEATH

15238

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Prestertown</u> c. LENGTH OF STAY in 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>400 Homerville Court</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u> d. STREET ADDRESS <u>53 N. Federal St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>BLANCHE HELMAN GELWICKS</u>				<b>4. DATE OF DEATH</b> Nov. 25, 1966			
<b>5. SEX</b> <u>2</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-14-01</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Franklin Co. Pa.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>David E. Helman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Sprenkle</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>172-24-7878</u>			
<b>17. INFORMANT</b> <u>Leon H. Gelwicks</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Hemorrhage - acute</u> DUE TO (b) <u>Leukemia - Chronic</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 years</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>November 25, 1966</u> <b>to</b> <u>November 25, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>November 25, 1966</u> <b>and that death occurred at</b> <u>11:15 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Clarence E. McWilliams</u>				<b>22b. DATE SIGNED</b> <u>11-25-1966</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Clarence E. McWilliams M.D.</u>				<b>22d. ADDRESS</b> <u>11904 Prestertown Rd. Prestertown Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-28-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rolling Spring Mennonite</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>P.R.S.I., Chambersburg, Pa.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert P. Darbour</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				<b>DATE</b> <u>NOV 20 1966</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

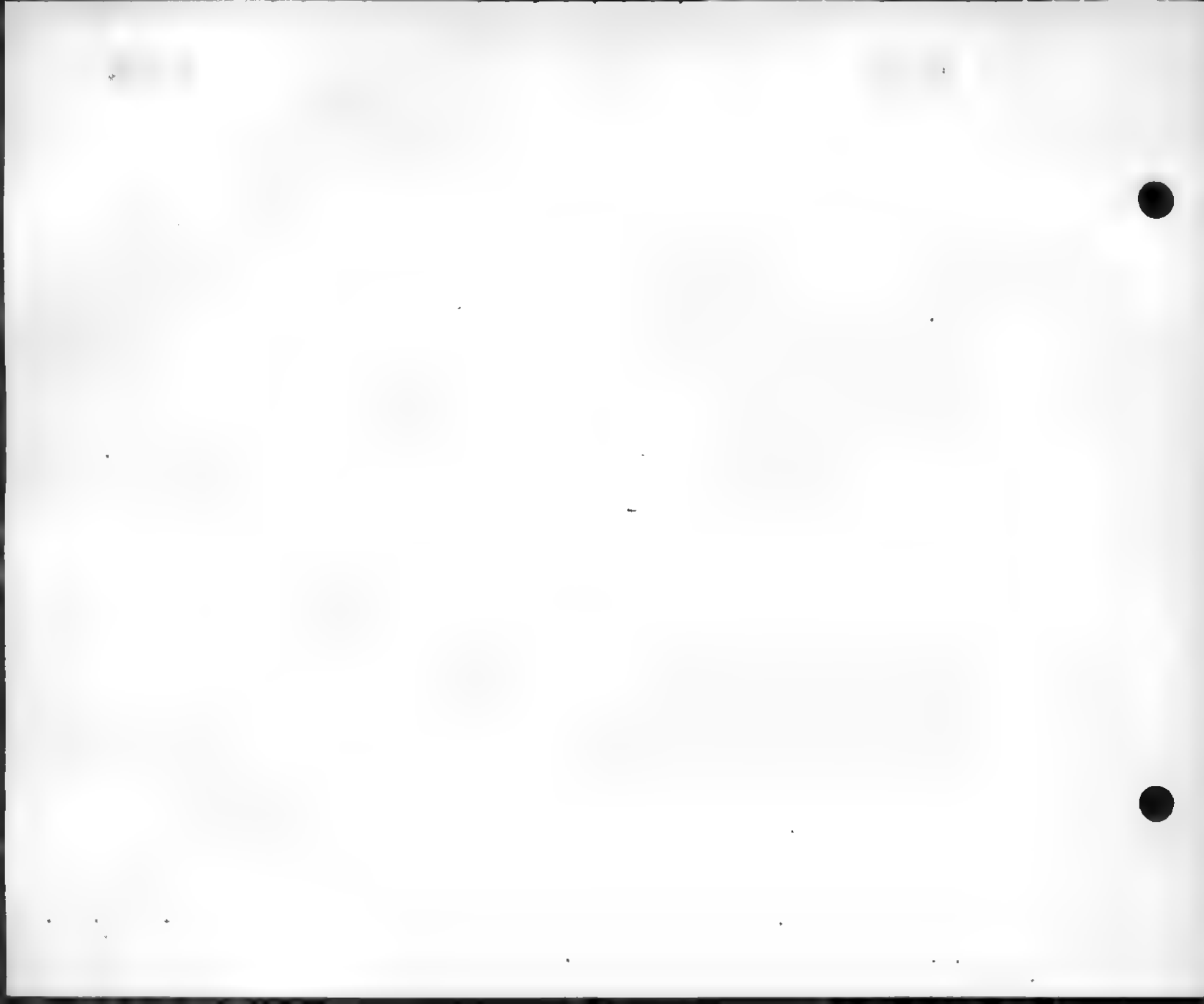
15241

## CERTIFICATE OF DEATH

15239

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Park Heights &amp; Walnut Aves.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> d. STREET ADDRESS <b>Park Heights &amp; Walnut Aves.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Sarah Frances Gill</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>November 29, 1966</b>													
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>August 9, 1890</b>		<b>9. AGE</b> (In years last birthday) <b>76</b> yrs <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min
IF UNDER 1 YEAR		IF UNDER 24 HRS															
Months	Days	Hours	Min														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>									
<b>13. FATHER'S NAME</b> <b>Joshua Raver</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Dearholt</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>215-32-2398</b>		<b>17. INFORMANT</b> Address <b>Mr. Harry E. Gill, Owings Mills, Md.</b>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis - acute</b> DUE TO (b) <b>Correlative Heart Failure - Chronic</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>Years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc)		<b>20f. (City or town) (County) (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from May 16, 1962, to November 29, 1966, that (I) (we) last saw the deceased alive on November 22, 1966 and that death occurred at M, from causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <b>Charles E. McWilliams</b> M.D.				<b>22b. DATE SIGNED</b> <b>11-29-66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b>  		<b>22d. ADDRESS</b> <b>Reisterstown Maryland</b>									
<b>23a. BURIAL, CREMATION, REMOVA.</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Dec. 2, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Grace</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Fall &amp; Ridge Rd. Balto. Md.</b>											
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> DATE <b>DEC 1 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or disposal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

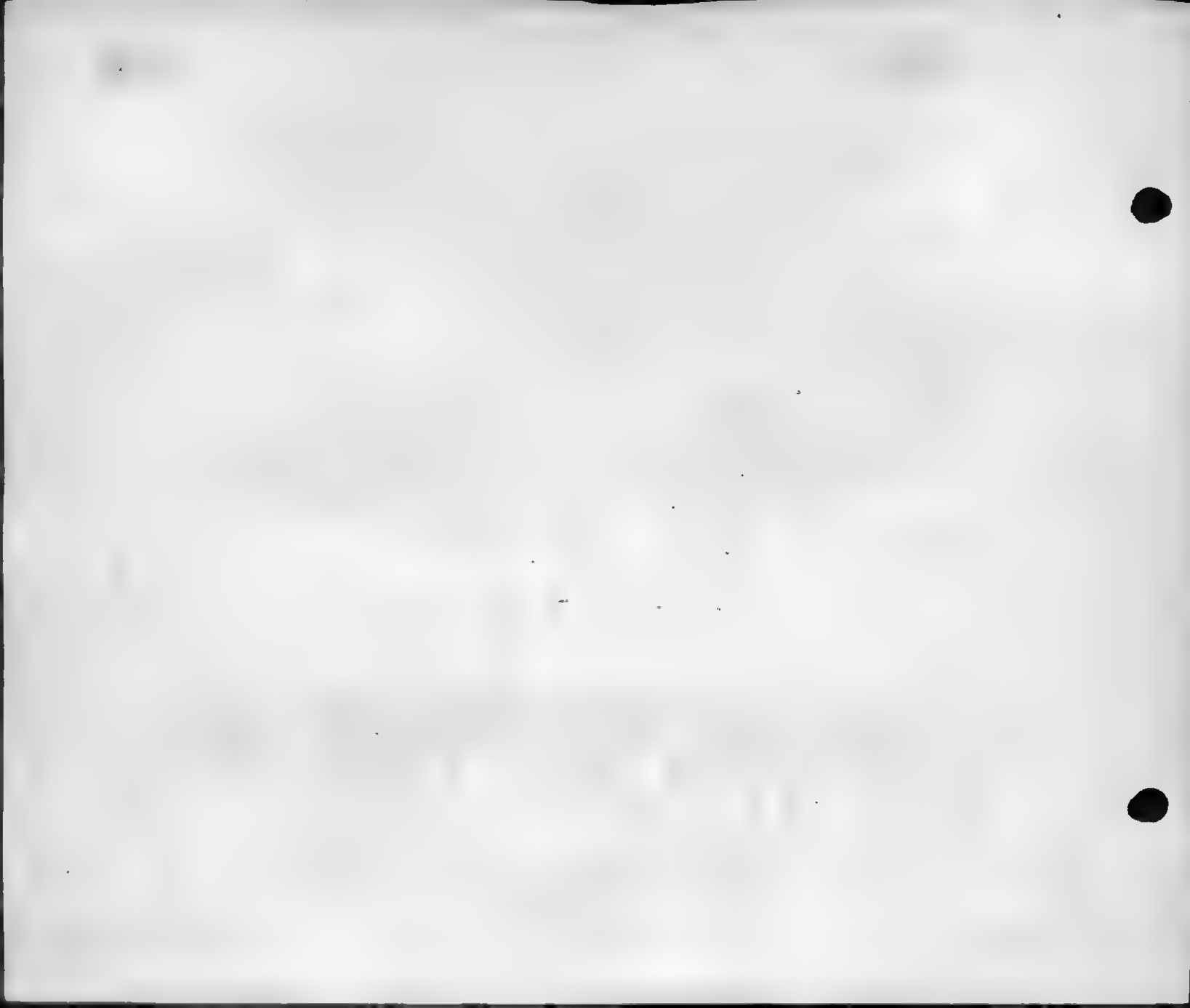
## CERTIFICATE OF DEATH

15242

15240

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>1 1/2 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2034 Northwind Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Henry</u> Middle <u>M.</u> Last <u>Gilliss</u>		<b>4. DATE OF DEATH</b> No. <u>6</u> , Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 14, 1883</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired-Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery Co., Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>John S. Gilliss</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Leannah Ricketts</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>214-12-0111</u>					
<b>17. INFORMANT</b> Name <u>Mrs. Gladys Wright Sykesville, Md.</u> Address <u>Rt. 4 Box 126</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Arteriosclerotic Cardio-Vascular Disease</u> (b) <u>② Diabetes Mellitus</u> (c) <u>③ Deep Vein Thrombosis</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, IF NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>10 yrs.</u> <u>2-2 1/2 yrs.</u>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>8/1/66</u> <b>to</b> <u>11/6/66</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/5/66</u> <b>and that death occurred</b> <u>11/6/66</u> <b>from the cause and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>W E McGrath</u>				<b>22b. DATE SIGNED</b> <u>11/6/66</u>				<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W E McGrath</u>					
<b>22d. ADDRESS</b> <u>1303 Frederick Rd Catonsville</u>				<b>22e. REC'D BY REGISTRAR</b>				<b>22f. REGISTRAR'S SIGNATURE</b> <u>John Charles Judge</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>11/10/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wrenzer Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Carroll Co., Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C. K. Voltz</u>				<b>ADDRESS</b> <u>Box 241 Sykesville, Md.</u>				<b>DATE</b> <u>NOV 10 1966</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

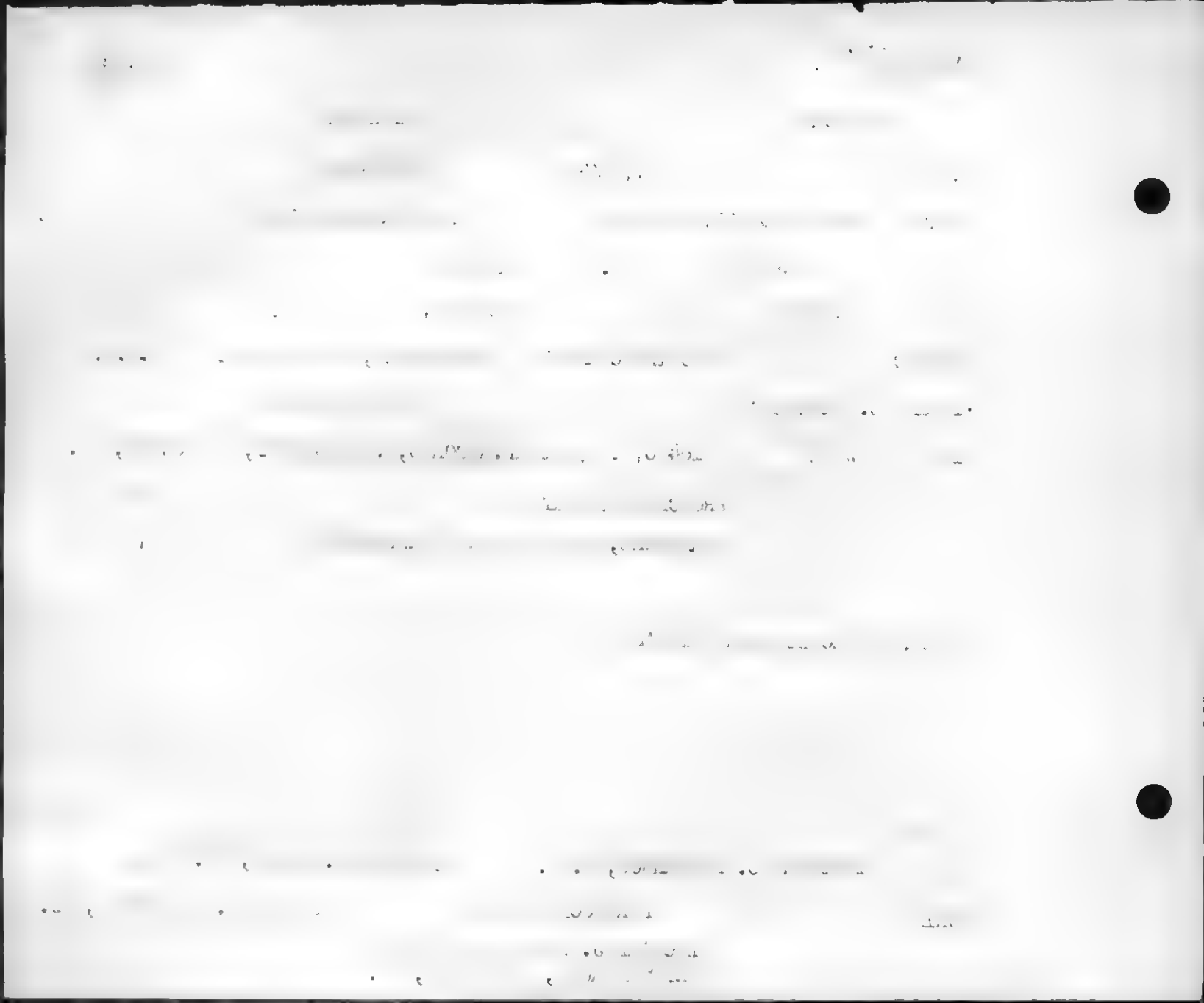
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15243

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15241

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>77 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3011 ECHODALE AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>A.</b> Last <b>GINTLING</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>8</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 26, 1893</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>WAYNESBORO, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM C. GINTLING</b>				14. MOTHER'S MAIDEN NAME <b>SALLY GROTTLE</b>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>FRACTURE, RIGHT HIP WITH INFECTION</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>78 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Theodore C. Patterson</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11/9/66</b>			
EXAMINER'S NAME (Type) <b>THEODORE C. PATTERSON, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>105 Main St. Balto, Md. 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>TAYLOR AVE. BALTIMORE, MD.</b>			
24. FUNERAL DIRECTOR <b>LEONARD J. RUCK FUNERAL HOME</b>		ADDRESS <b>HARFORD ROAD, BALTIMORE, MD.</b>		25a. REC'D BY REGISTRAR <b>1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

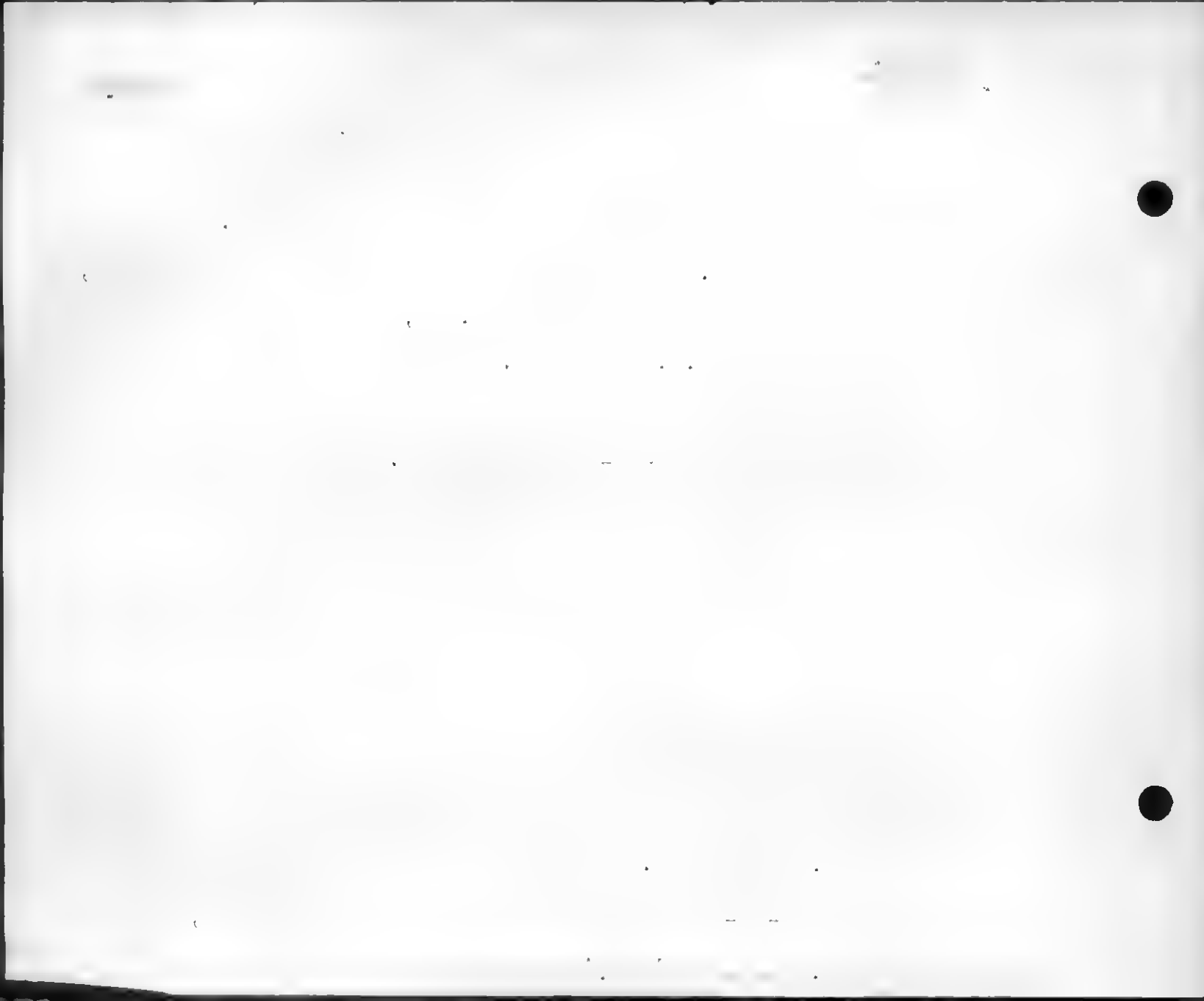
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15244

## CERTIFICATE OF DEATH

15242

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 'b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>131</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Home</b>				d. STREET ADDRESS <b>607 Dunkirk Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John F. Gisriel</b> First Middle Last				4. DATE OF DEATH <b>November 10, 1966</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 25, 1886</b>	
9. AGE (In years last birthday) <b>79</b>		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cloth Examiner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>F.J. Hanson Co.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John Coyle Gisriel</b>				14. MOTHER'S MAIDEN NAME <b>Martha Cushrein</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-5615</b>		17. INFORMANT <b>Bernard E. Gisriel</b> Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Myocardial Infarction - Ruptured Aorta</b> DUE TO (c) <b>Arteriosclerosis CVD</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>11-10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-3</b> , 19 <b>66</b> , and that death occurred at <b>6:40 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence J. Shimanek</b> PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>11-11-66</b>			
22d. ADDRESS <b>3711 Falls Road</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-12-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b> ADDRESS <b>6500 York Rd. Baltimore, Md. 21212</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

items 14, 236 film 358 12/2/66 mh

15245

# CERTIFICATE OF DEATH

15243

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>44 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD GITTINGS</b>		4. DATE Month Day Year <b>DEATH NOVEMBER 28, 19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12 30 10</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>MAINTENANCE</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM J. GITTINGS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>215 01 6337</b>	
17. INFORMANT <b>CLIN. REC., VAH, FORT HOWARD, MARYLAND</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>OCT. 15, 19 66</b> , to <b>NOV. 28, 19 66</b> , that (X) (we) last saw the deceased alive on <b>NOV. 28, 19 66</b> , and that death occurred at <b>11:00 P.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Lawrence F. Awalt, Jr.</i> M.D.		22b. DATE SIGNED <b>11/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/2/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Elroy O. Wilson</i>		25. REC'D BY REGISTRAR <b>ELROY O. WILSON FUNERAL HOME</b> DATE <b>NOV 29 1966</b> <b>ORLEANS ST. BALTIMORE, MD.</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

THE UNIVERSITY OF CHICAGO

THE HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15246 CERTIFICATE OF DEATH 15244

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN ID <b>4 months</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>2403 Barclay Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>GLASCO</b> Last <b>GLASCO</b>				4. DATE OF DEATH Month <b>11</b> Day <b>6</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-4-53</b>	
9. AGE (In years last birthday) <b>13</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Randolph Glasco, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Brown (Deceased)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale, heart failure</b> DUE TO (b) <b>Reticuloendotheliosis?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>6-21</b> , 19 <b>66</b> , to <b>11-6</b> , 19 <b>66</b> , that (he) (we) last saw the deceased alive on <b>11-6</b> , 19 <b>66</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED <b>11-10-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Zsolt Koppanyi, M.D.</b>	
22d. ADDRESS <b>Rosewood State Hosp., Owings Mills, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Owings Mills, Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>Reisterstown, Md.</b>			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				DATE <b>NOV 14 1966</b>			

MEDICAL CERTIFICATION



TO HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

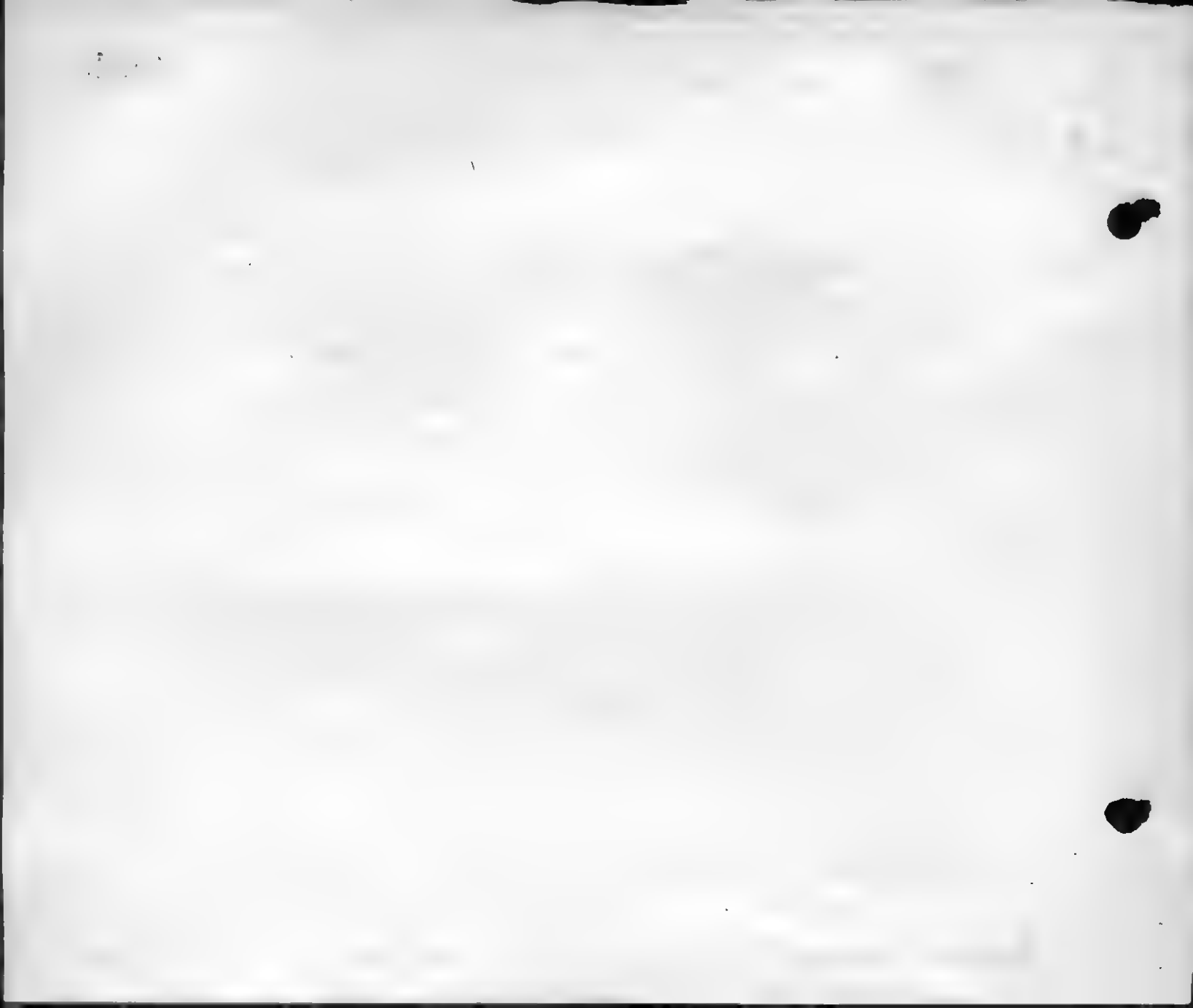
15247

## CERTIFICATE OF DEATH

15245

Item 3 Film G 394 10/30/67 1b

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2413 York Road.		d. STREET ADDRESS 2413 York Rd.	
3. NAME OF DECEASED (Type or print) Elizabeth Goszka		4. DATE OF DEATH Nov. 24 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. DATE OF BIRTH Nov. 11-1895.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Cleveland, Ohio.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Klebowski		14. MOTHER'S MAIDEN NAME Katherine Klebowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Leona Blumenfeld 1221 Seven Oaks Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause par line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ASCENDING COLON DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/13/66, to 11/24/66, that (I) (we) last saw the deceased alive on 11/21/66, and that death occurred at 11/24/66, from the causes and on the date stated above.			
22a. SIGNATURE William A. Pillsbury		22b. DATE SIGNED 11-26-66	
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury		22d. ADDRESS Timonium, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28-66.	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Richard R. Kasey		25a. REC'D BY REGISTRAR DATE NOV 29 1966	
ADDRESS 5646 Carville Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

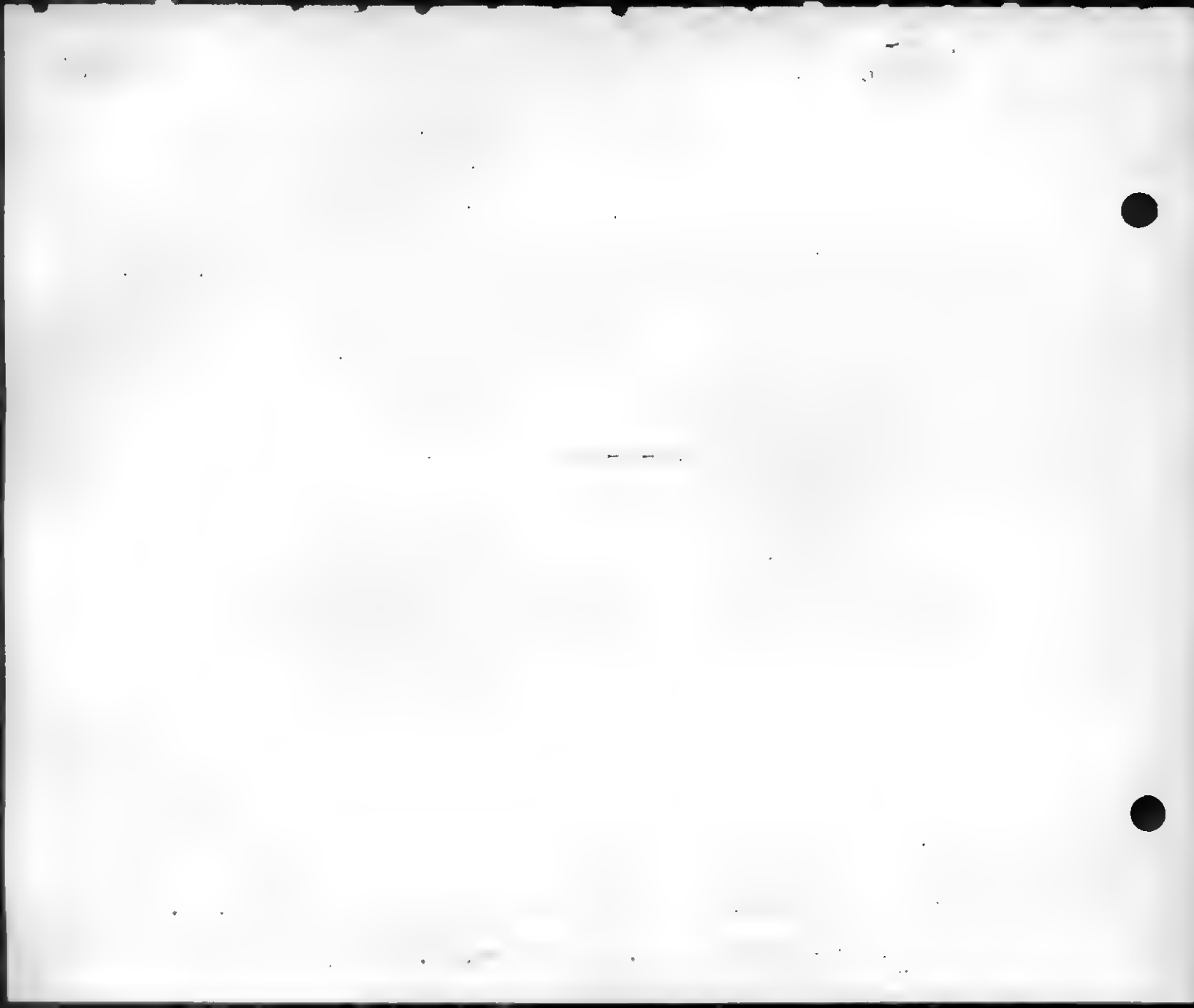
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15248

15246

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
c. LENGTH OF STAY IN 1b <u>3 wks.</u>			d. STREET ADDRESS <u>8819 Flagstone Drive</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Med. Center</u>					
3. NAME OF DECEASED (Type or print) <u>Arthur Phillip Gourd</u>			4. DATE OF DEATH <u>11-27-66</u> 19 <u>66</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-7-88</u>		9. AGE (in years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			11b. KIND OF BUSINESS OR INDUSTRY		
12. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>			13. CITIZEN OF WHAT COUNTRY?		
14. FATHER'S NAME <u>Lawrence Gourd</u>			15. MOTHER'S MAIDEN NAME <u>Mary Dorsey</u>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			17. SOCIAL SECURITY NO. <u>216-09-9076</u>		
18. INFORMANT <u>Patient's Chart</u>			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> <u>163X</u> DUE TO (b) <u>Metastatic leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Carcinoma of the lung</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 2</u> , 19 <u>66</u> , to <u>November 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>November 27</u> 19 <u>66</u> , and that death occurred at <u>4 4</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>D. Kuwilsky</u>						22b. DATE SIGNED <u>11-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dora C. Kuwilsky</u>						22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15249

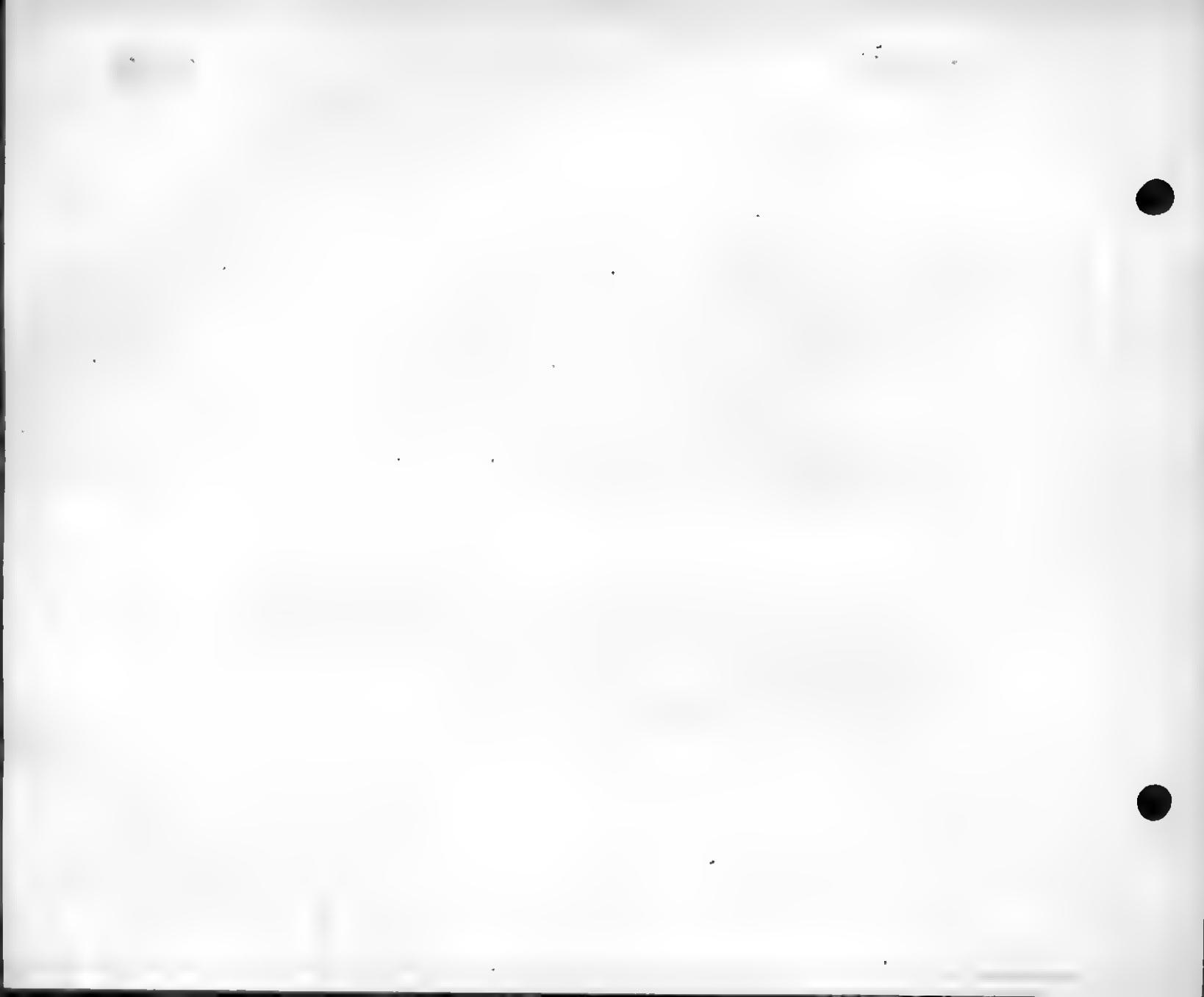
CERTIFICATE OF DEATH

15247

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2017 SULPHUR SPRING ROAD 21227</b>		d. STREET ADDRESS <b>2017 SULPHUR SPRING ROAD, #27</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN S. GRABOWSKI</b>		4. DATE OF DEATH Month Day Year <b>NOV. 7, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1889</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JULIAN GRABOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>ANNA-----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>216-34-2453</b>	
17. INFORMANT <b>MRS. MARY A. GRABOWSKI</b>		Address <b>2017 Sulphur Spring Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Thrombosis</b> DUE TO (b) <b>Generalized A. S. C. V.D.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/11, 1966</b> to <b>11/7, 1966</b> , that (I) (we) last saw the deceased alive on <b>11/4, 1966</b> , and that death occurred at <b>1:32 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John C. Healy</b>		22b. DATE SIGNED <b>11/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. HEALY</b>		22d. ADDRESS <b>1311 FRANCIS AVENUE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-10-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue, 21229</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 10 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1401

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 8 Film 6383 12/2/66 mh

15250

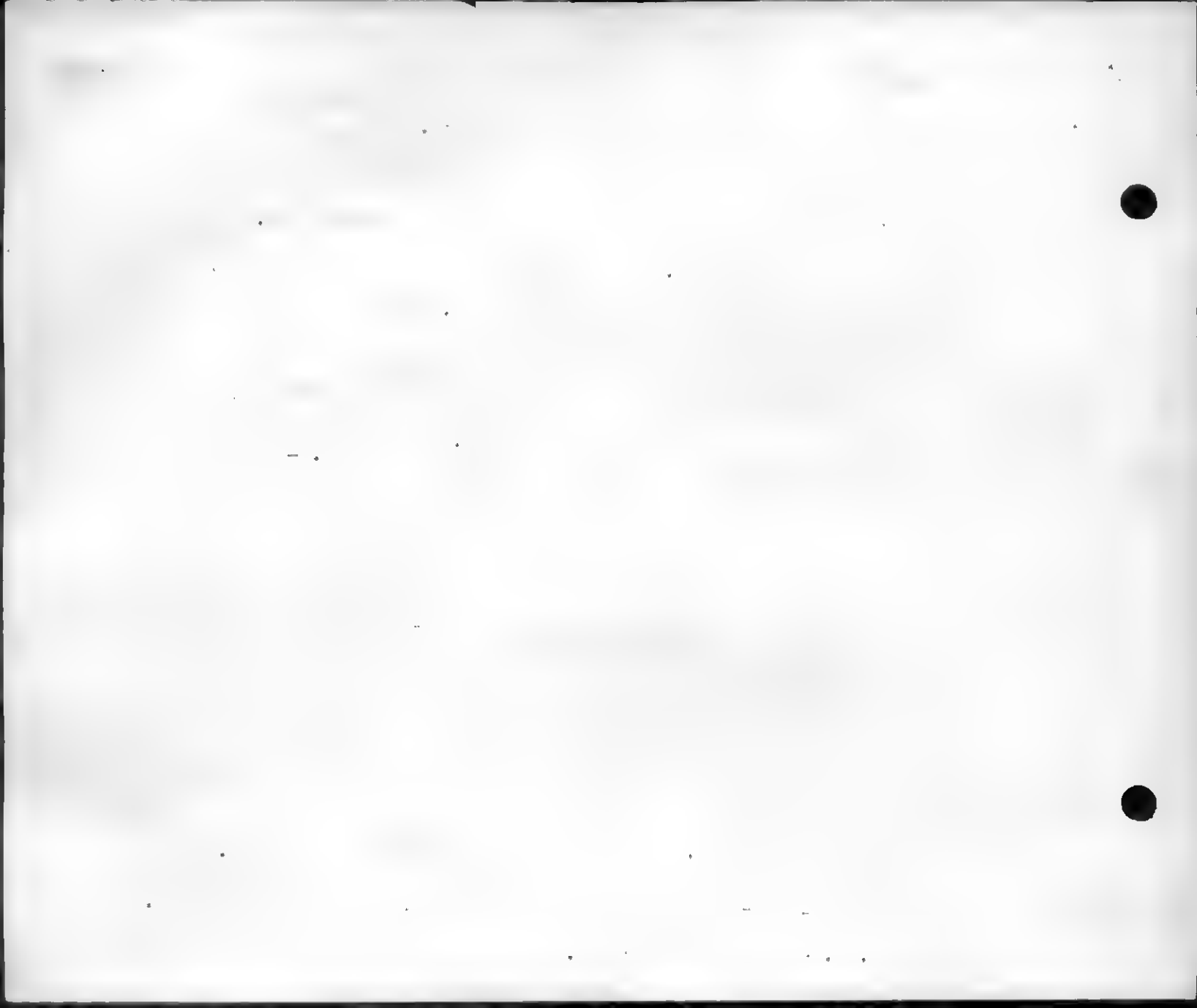
CERTIFICATE OF DEATH

15248

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN TB <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La Nursing Home</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4629 Edmondson Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Hilda C. Graham</b> First Middle Last		4 DATE OF DEATH <b>Nov. 25 1966</b> Month Day Year	
5 SEX <b>F</b>	6 COLOR OR RACE <b>Wh</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 28/83 1884</b>
9 AGE (In years birth day) yrs <b>82</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Late - Charles Van Lill</b>		14. MOTHER'S MAIDEN NAME <b>Late - Sarah A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mrs. Regina Melder</b> <b>203 Rockglen Rd. - #29</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory failure</b> DUE TO (b) <b>Dehydration + Malnutrition</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Brain Degeneration</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>Nov 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>25 Nov. 1966</b> , and that death occurred at <b>2 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>William J. Bryson</b> 22c. PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>		22b. DATE SIGNED <b>25 Nov 66</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>4605 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVA (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15251

15249

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Rural)</b>		c. LENGTH OF STAY in 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 40, E. of Jones Road</b>		e. STREET ADDRESS <b>823 Aisquith Street</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>GRAHAM</b>		4 DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12 April 1945</b>
9 AGE (In years last birthday) yrs <b>21</b>		10 IF UNDER 1 YEAR Months <b>21</b> Days <b>18</b> Hours <b>18</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Janitorial</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Harry Graham</b>		14 MOTHER'S MAIDEN NAME <b>Annie Scruggs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-46-0418</b>	
17. INFORMANT <b>Harry Graham, Perryman, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Extreme Craniocerebral Injury.</b> <b>XIB1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Acute ethylism</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18) <b>Driver in auto-truck collision.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11/18</b> pm <b>1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		22. DATE SIGNED <b>11/19/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Calvary Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Aberdeen, Maryland</b>	
24. FUNERAL DIRECTOR <b>John G. Tarring</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		Address <b>Aberdeen, Md.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15252

CERTIFICATE OF DEATH

15251

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHADY NOOK NURSING HOME</u>		d. STREET ADDRESS <u>4 S. Beechwood Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>ELEANOR</u> Middle <u>T.</u> Last <u>GRAY</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>12</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11, 1876</u>
9. AGE (in years last birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Thrope</u>		14. MOTHER'S MAIDEN NAME <u>SARAH CHADWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>MR. Charles Rosenthal</u>		Address <u>4 S. Beechwood</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO <u>Cardio-vascular Heart disease</u> (b) <u>Hypertension - Angina</u> DUE TO <u>  </u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1935</u> , 19 <u>  </u> , to <u>11-12-66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>11-12</u> 19 <u>66</u> , and that death occurred at <u>11A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Wetherbee Fort</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>		22d. ADDRESS <u>6 Dutton Ave, Catonsville 28</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. Johns Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR <u>E. S. Mae Nabb</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 16 1966</u>	
ADDRESS <u>301 Frederick Rd. Baltimore 28 Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1. 21. 9

1. 19. 21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

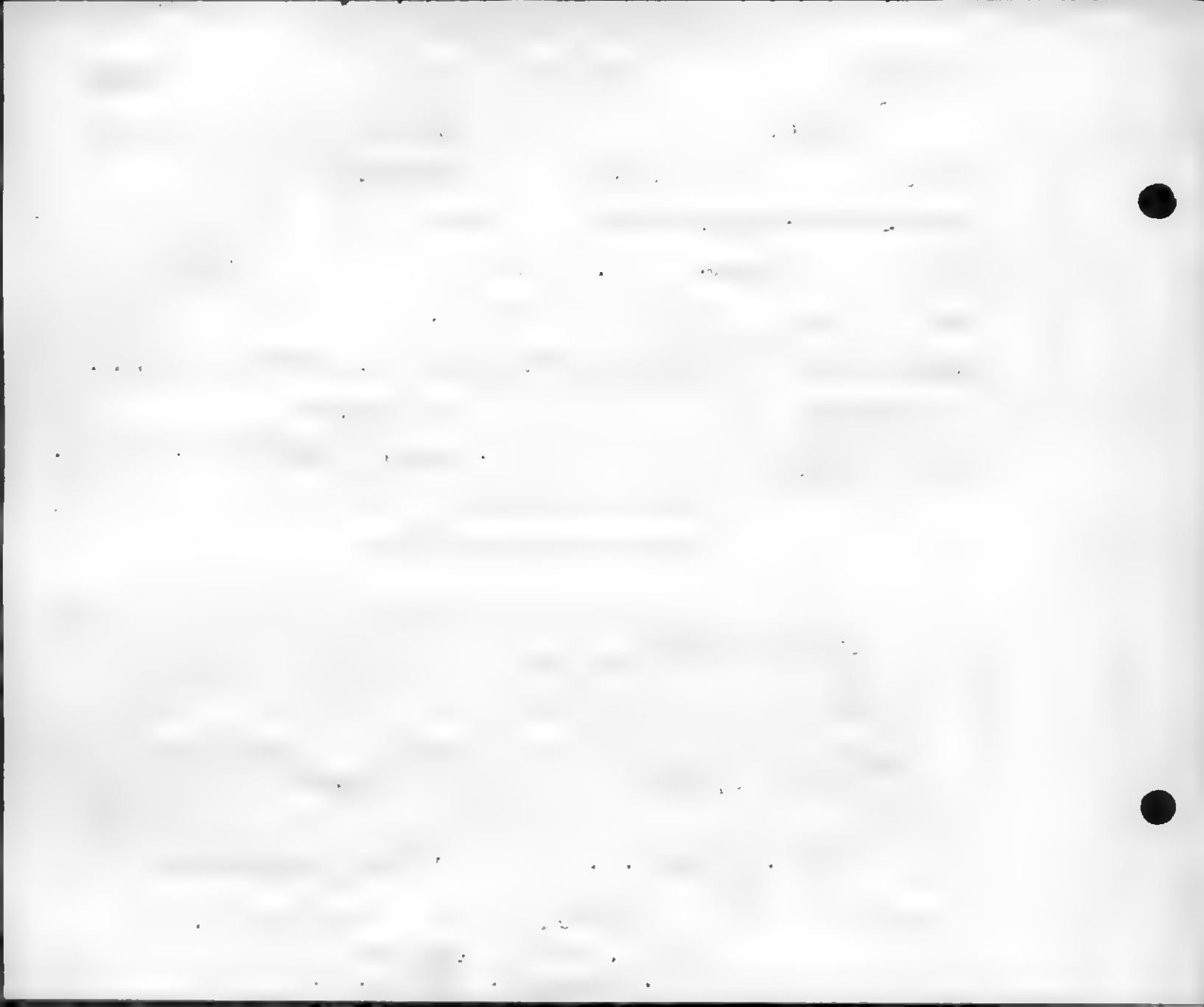
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M

1

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15253					15252					
1 PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)					
a. COUNTY <b>BALTIMORE</b> MARYLAND					a. STATE <b>MARYLAND</b> b. COUNTY <b>MONROESTER</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<b>FORT HOWARD</b>				<b>11 HOURS</b>	<b>OCEAN CITY</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>VETERANS ADMINISTRATION HOSPITAL</b>					<b>ROUTE 1</b>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		Month		Day Year	
First <b>WILLIAM</b> Middle <b>J.</b> Last <b>GRAY</b>					<b>NOVEMBER</b>		<b>17</b>		<b>19 66</b>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min	
<b>MALE</b>	<b>WHITE</b>		<b>MAY 17, 1891</b>		<b>75</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<b>MACHINE ASSEMBLY</b>			<b>PAPER MACHINERY</b>		<b>HOKENDAQUA, PENNSYLVANIA</b>			<b>U.S.A.</b>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<b>WILLIAM GRAY</b>					<b>MARY ANN WARK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address					
<b>YES WW I</b>			<b>221 01 36 95</b>		<b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										<b>UNKNOWN</b>
IMMEDIATE CAUSE (a) <b>CARDIAC DECOMPENSATION</b>										
DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>DIABETES MELLITUS</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/17/66</b> , 19 to <b>11/17/66</b> , 19, that (1) (we) lost the deceased alive on <b>11/17/66</b> , 19, and that death occurred at <b>10:15 PM</b> from causes and on the date stated above.										
22a. SIGNATURE <b>J. D. Talbert</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11/17/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>					22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>Nov 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR DATE <b>NOV 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
<b>Joseph N. Zannino Funeral Home</b>					<b>257 S. Conkling St. Baltimore, Md.</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exempted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

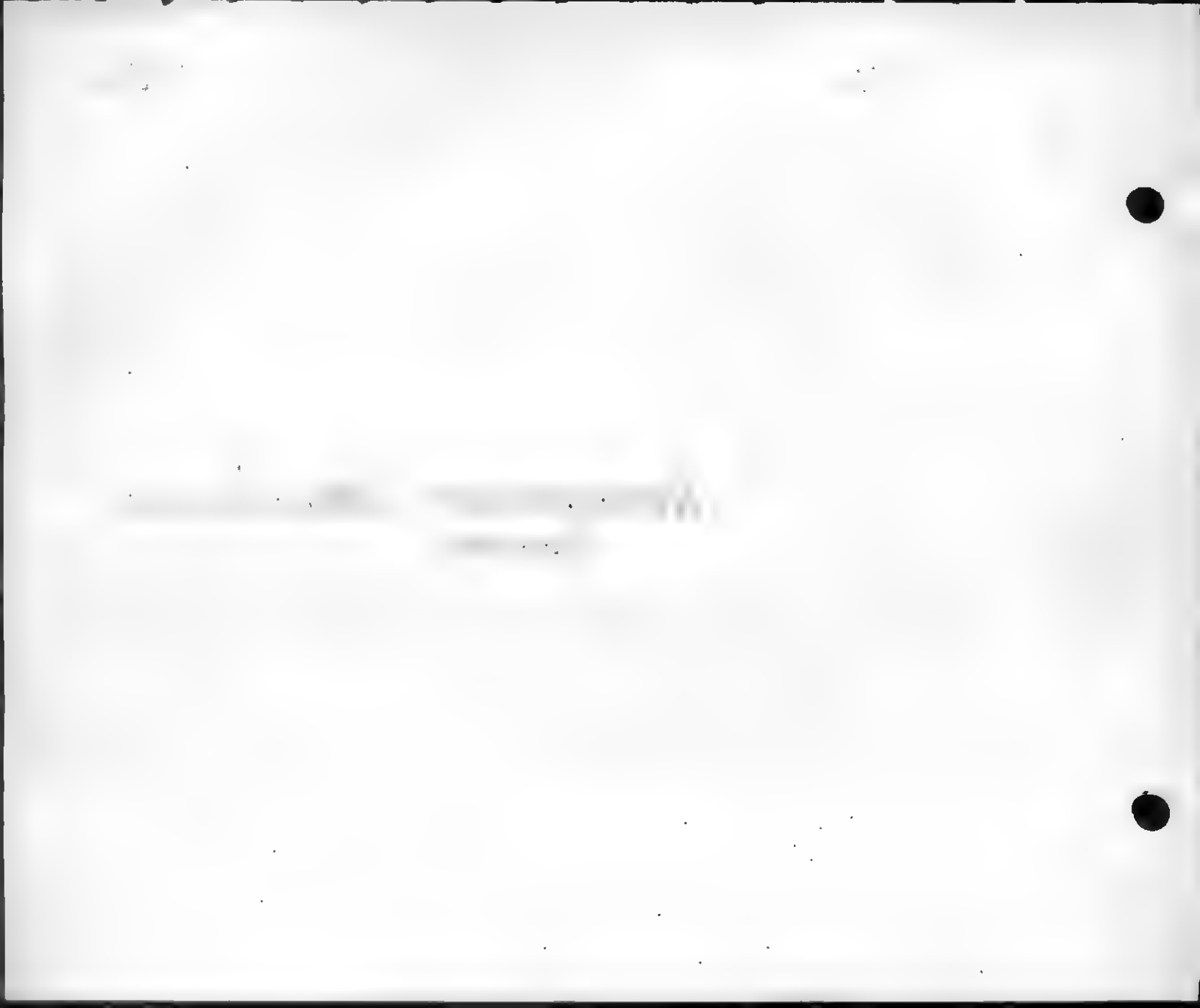
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15254

15253

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keisterstown - Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>Ridge Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edgar Eugene Greaser</u>		4. DATE OF DEATH Month Day Year <u>11/21/66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/16</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Greaser</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>DISEASE</u> DUE TO (c) <u>DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>November 21, 1966</u> , to <u>November 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 21, 1966</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edathil K. S. Narayanan</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDATHIL K. S. NARAYANAN</u>		22d. ADDRESS <u>INTERN, GREATER BALTO. MED. CENTER, TOWSON</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAY'S CHAPEL CEMETERY</u>	23d. LOCATION (city, town or county) (State) <u>LUTHERVILLE, MD.</u>
24. FUNERAL DIRECTOR <u>John Bruno Sons Towson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

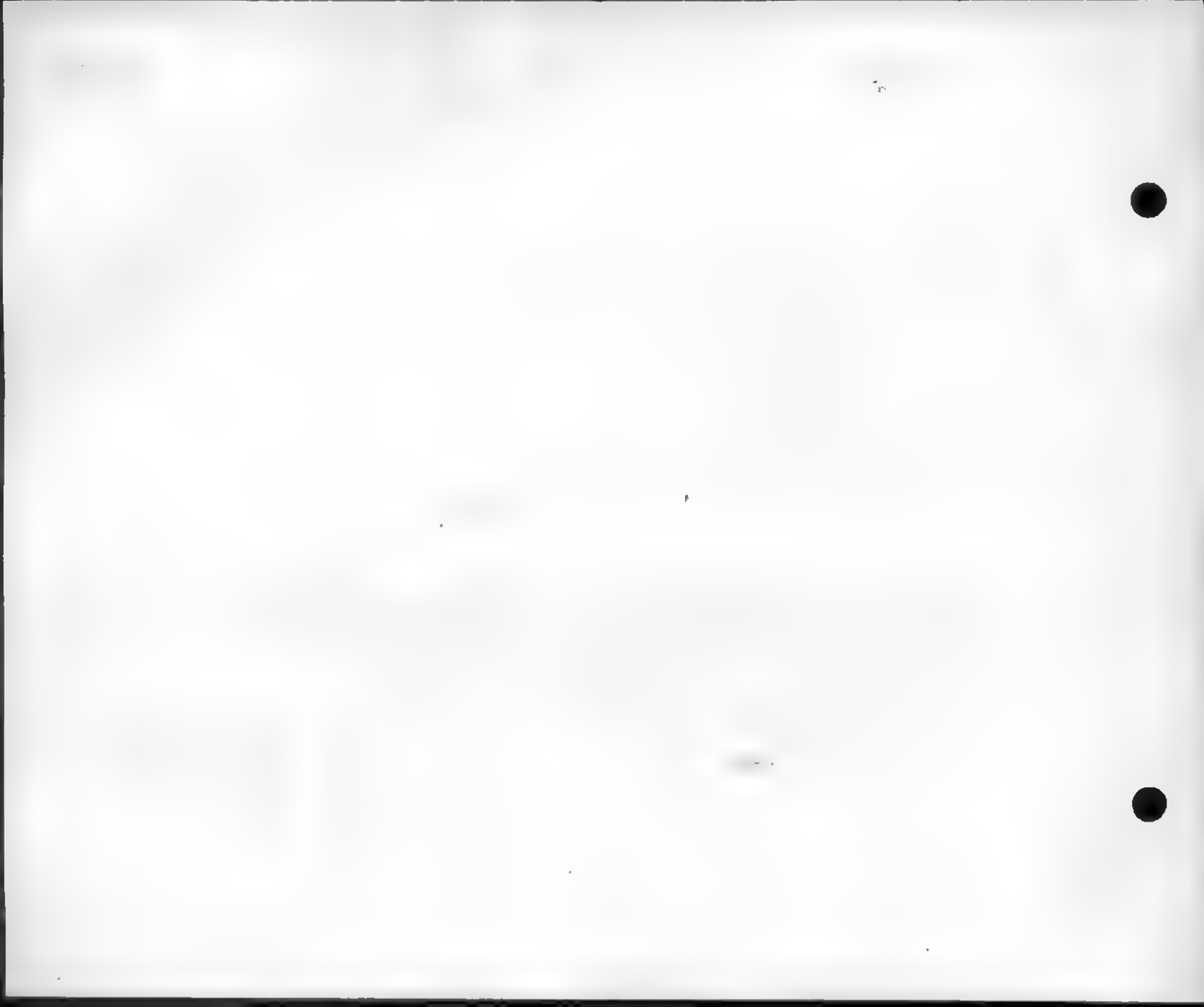
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15255

CERTIFICATE OF DEATH

15254

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHADY NOOK HOME</u>				d. STREET ADDRESS <u>711 EASTSHIRE DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>EDGAR C. GRETSKY</u> First Middle Last				4 DATE OF DEATH <u>NOV 22 1966</u> Month Day Year			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/7/1889</u>	9. AGE (In years last birthday) <u>77</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAN GRECKI</u>				14. MOTHER'S MAIDEN NAME <u>ANIELA WASOWICZ</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY A. GRETSKY</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lung.</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 24, 1966</u> , to <u>Nov 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 21, 1966</u> , and that death occurred at <u>3:00 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John A. Nesbitt, Jr., M.D.</u>				22d. ADDRESS <u>1009 Frederick Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		23d. LOCATION (City or town) (County) (State) <u>BALTO. CC MD</u>	
24. FUNERAL DIRECTOR <u>E.S. MALNABIS</u>				25a. REC'D BY REGISTRAR <u>212228</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

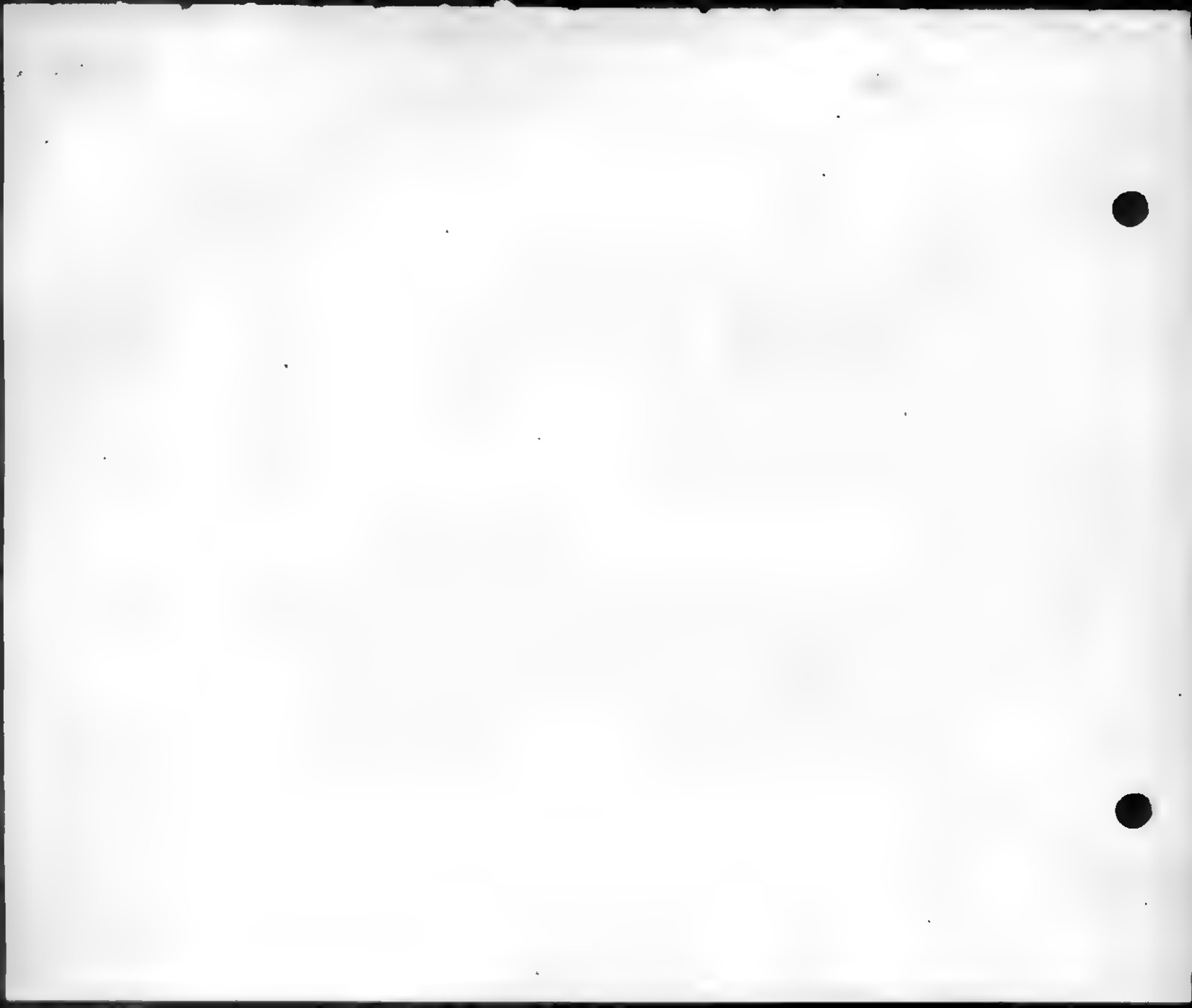
15256

CERTIFICATE OF DEATH

15255

Item 23 Film G382-11/14/66 mb

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>8 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>7810 OVERBROOK, Ruxton</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEFFERSON CLEVELAND GRINHALDS</b> First Middle Last 4. DATE OF DEATH <b>11 6 1966</b> Month Day Year		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>5-4-84</b> 9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CITY EMPLOYEE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b> 11. BIRTHPLACE (County & State, or foreign country) <b>PARKSLEY VIRGINIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JEFFERSON DAVIS GRINHALDS</b> 14. MOTHER'S MAIDEN NAME <b>TWYFORD, Roberta Sarah</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>216-32-8469</b> 17. INFORMANT <b>CATHERINE GRINHALDS.</b> Address <b>SAME.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA METASTASIS</b> DUE TO (b) <b>CA. PROSTATE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C. V. A.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>13 Mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>10-31</b> , 19 <b>66</b> , to <b>11-6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-6</b> , 19 <b>66</b> , and that death occurred at <b>3:25 P.M.</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>D. Negrete</b> 22b. DATE SIGNED <b>11-6-66</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>DANIEL F. NEGRETE</b> 22d. ADDRESS <b>2909 FALLSTAFF RD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/9/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b> 23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>NOV 9 1966</b> 25b. REGISTRAR'S SIGNATURE	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

15256

 FOR STATE  
HEALTH DEPT.

15257

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Rosedale</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1902 Longview Ave</b>		e. STREET ADDRESS <b>1902 Longview Ave</b>	
3. NAME OF DECEASED (Type or print) <b>FRANK Joseph GROH JR.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-12</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>54</b> Days <b>12</b> Hours <b>54</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPER. ENG.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland General</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK J GROH</b>		14. MOTHER'S MAIDEN NAME <b>MARY A. -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>094 01 4988</b>	
17. INFORMANT <b>GRACE GROH</b>		Address <b>1902 Longview Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-I-D-E-A-S-E</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.1</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS M.D.</b>		DATE SIGNED <b>12/1/66</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-3-66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadowdale Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Howard County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip F. Green</b>		ADDRESS <b>1211 Chesebrough Ave.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>DEC 5</b>		<b>1966</b>	

 VS. A15ME  
SM 2/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 28 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Made a 5th copy returned to Dr. Davis 12/1/66



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

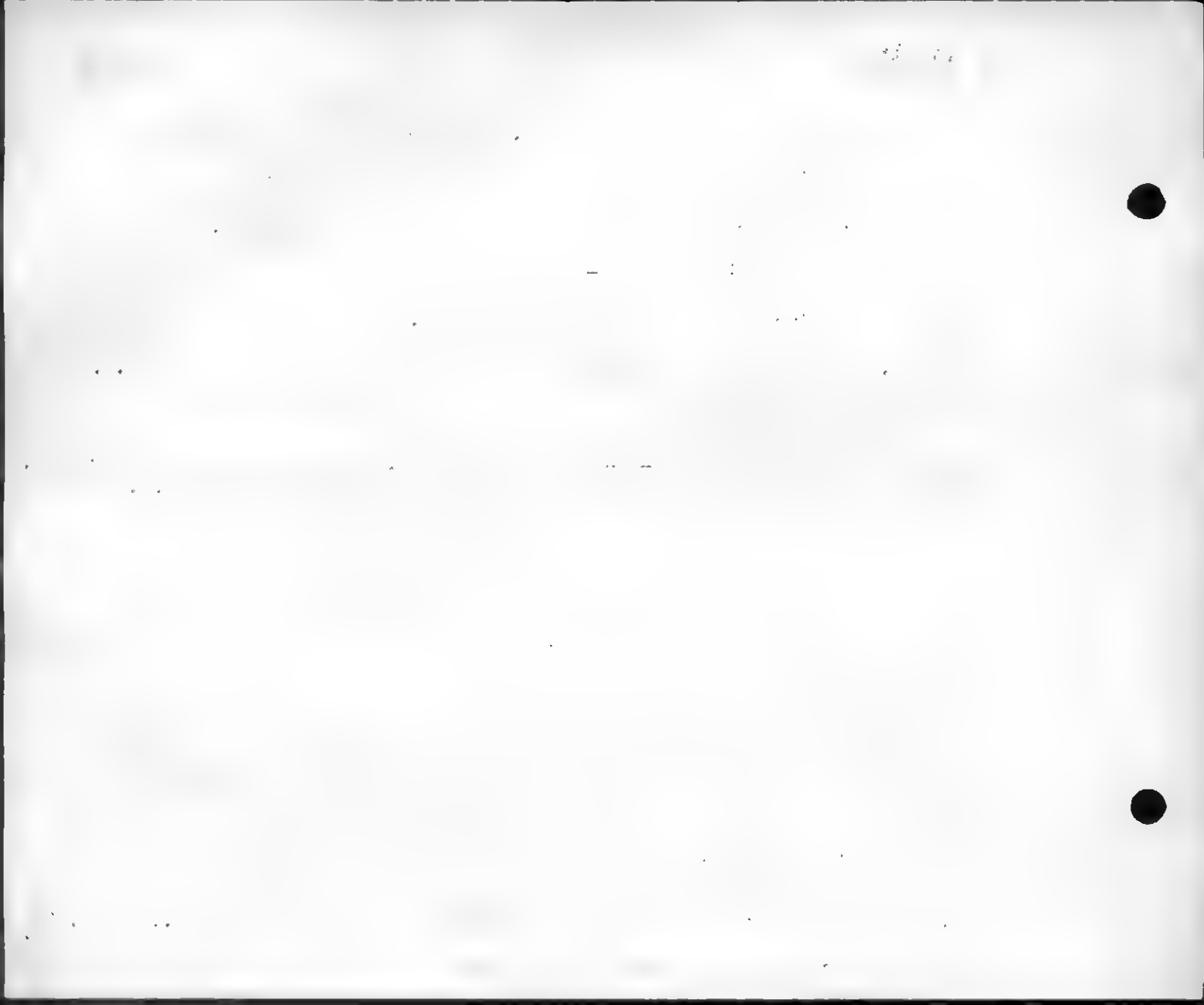
15258

## CERTIFICATE OF DEATH

15257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Baltimore</b>			c. LENGTH OF STAY IN 1b <b>Rural Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7306 Prince George Road</b>			d. STREET ADDRESS <b>7306 Prince George Rd.</b>		
3. NAME OF DECEASED (Type or print) First <b>Felix</b> Middle <b>-</b> Last <b>Grue</b>			4. DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 3, 1889</b>		9. AGE (In years last birthday) yrs. <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mfg. Clothing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (County & State or foreign country) <b>Italy</b>	
12. FATHER'S NAME <b>Pasquale Grue</b>		14. MOTHER'S MAIDEN NAME <b>DiGuseppi (Theresa D.)</b>			
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO <b>216-03-79988</b>		17. INFORMANT <b>Anna E. Grue</b> Address <b>7306 Prince George Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Ischemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ischemia</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Baltimore</b> (County) <b>MD</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 18, 1966</b> , to <b>Nov. 19, 1966</b> , that (I) (we) lost the deceased alive on <b>Nov. 18, 1966</b> , and that death occurred at <b>3:15 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Raymond M. Cunningham</b>			22b. DATE SIGNED <b>11-20-66</b>		22c. PHYSICIAN'S NAME (Type) <b>R. M. CUNNINGHAM</b>
22d. ADDRESS <b>823 MEDICAL APTS BALDG BALTO, 21201</b>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
23d. LOCATION (City or Town) <b>4430 Belair Rd., Balto.</b>		23e. (County) <b>MD</b>		23f. (State)	
24. FUNERAL DIRECTOR <b>Loring Byers</b>			25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c. ADDRESS <b>8728 Liberty Road</b>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15259

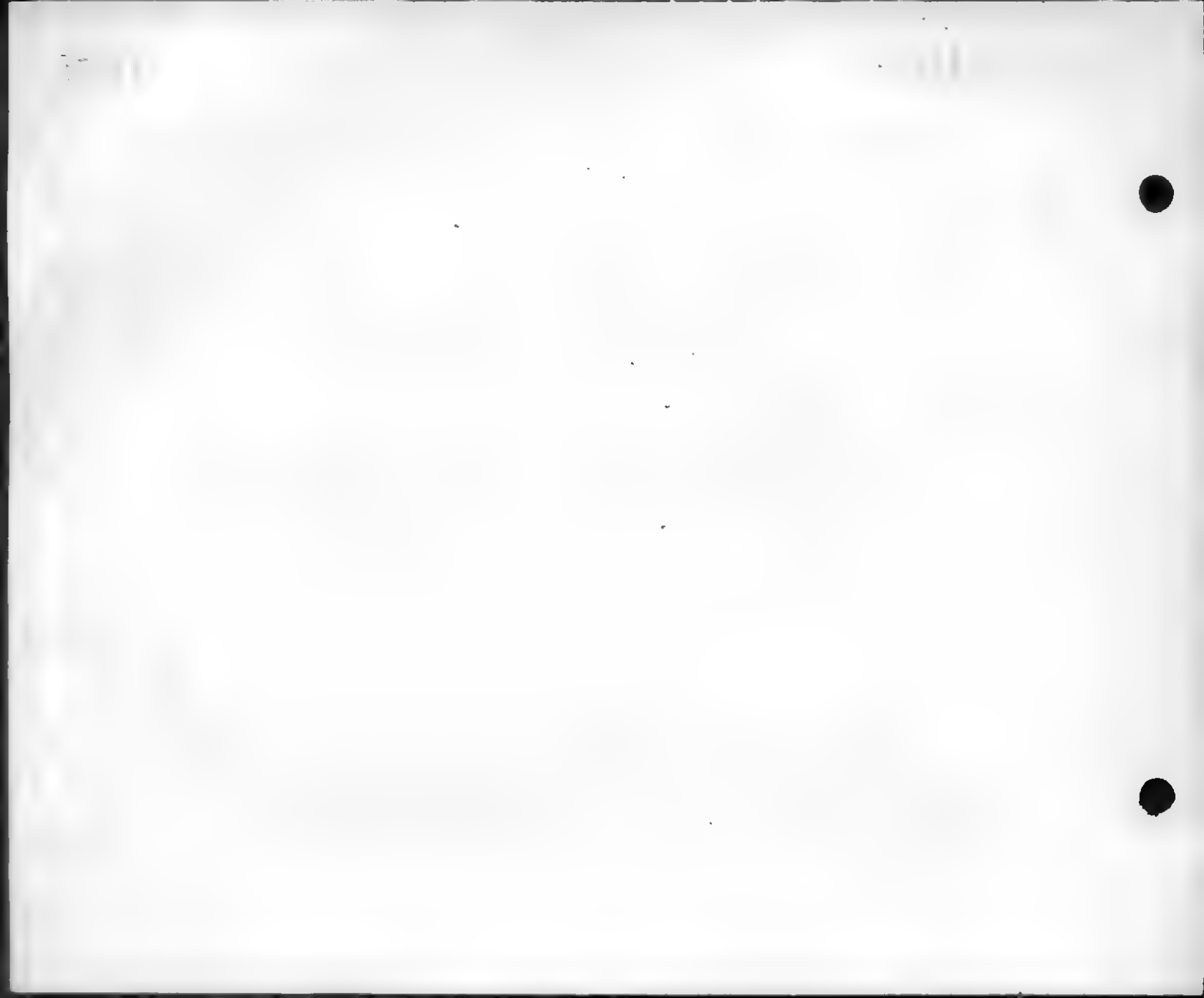
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15258

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>MD</u> b COUNTY <u>BALTO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c LENGTH OF STAY IN 1b <u>55 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AT-HOME</u>		d. STREET ADDRESS <u>426 MARYLAND</u>	
3 NAME OF DECEASED (Type or print) <u>WILLIAM M. HAGY</u>		4 DATE OF DEATH <u>Nov 3 19 66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JULY 18- 1902</u>
9. AGE (In years last birthday) <u>64</u>		F UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. OIL CO.</u>	
11 BIRTHPLACE (State or foreign country) <u>PA.</u>		12 C ITIZEN OF WHAT COUNTRY <u>U.S. A.</u>	
13 FATHER'S NAME <u>WILLIAM D. HAGY</u>		14 MOTHER'S MAIDEN NAME <u>MURPHY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Inez Hagy (wife)</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>* Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V- Disease</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 7- 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore MD.</u>	
24 FUNERAL DIRECTOR <u>J. J. Connelly-Sons</u>		25 ADDRESS <u>300 N. Mace (21)</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 7 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

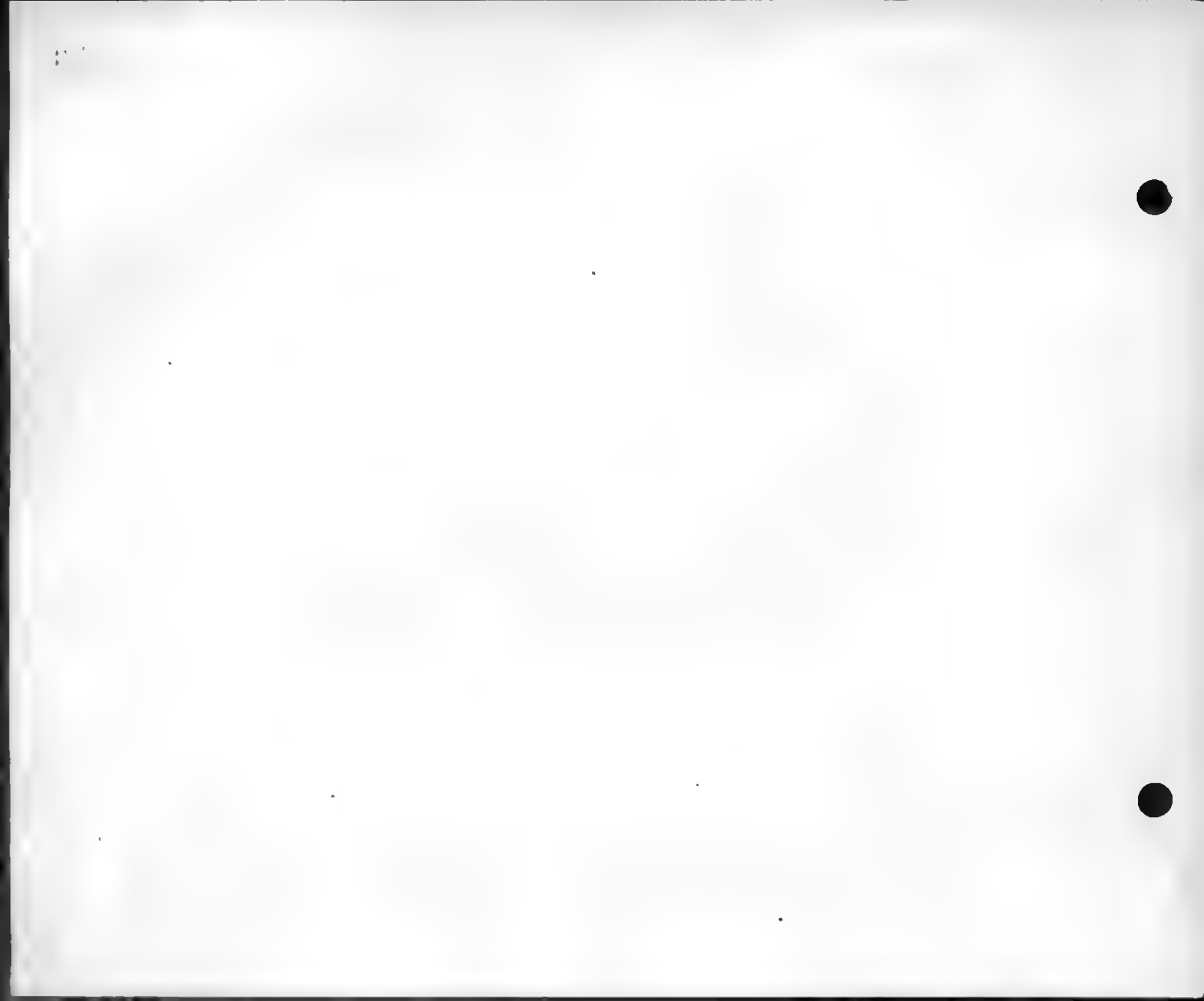
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15260

CERTIFICATE OF DEATH

15259

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>507 West Chesapeake Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Doris Devore Haller</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Zachary</b>		14. MOTHER'S MAIDEN NAME <b>Josephine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO <b>214-01-4268-B</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> 400 X DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from <b>Oct. 18, 19 66</b> to <b>Nov. 17, 19 66</b> , that (s) (we) last saw the deceased alive on <b>Nov. 17, 19 66</b> , and that death occurred at <b>3:55</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Ricardo Ibanez</b> M.D.		22b. DATE SIGNED <b>11-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICARDO IBANEZ</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John Burns</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

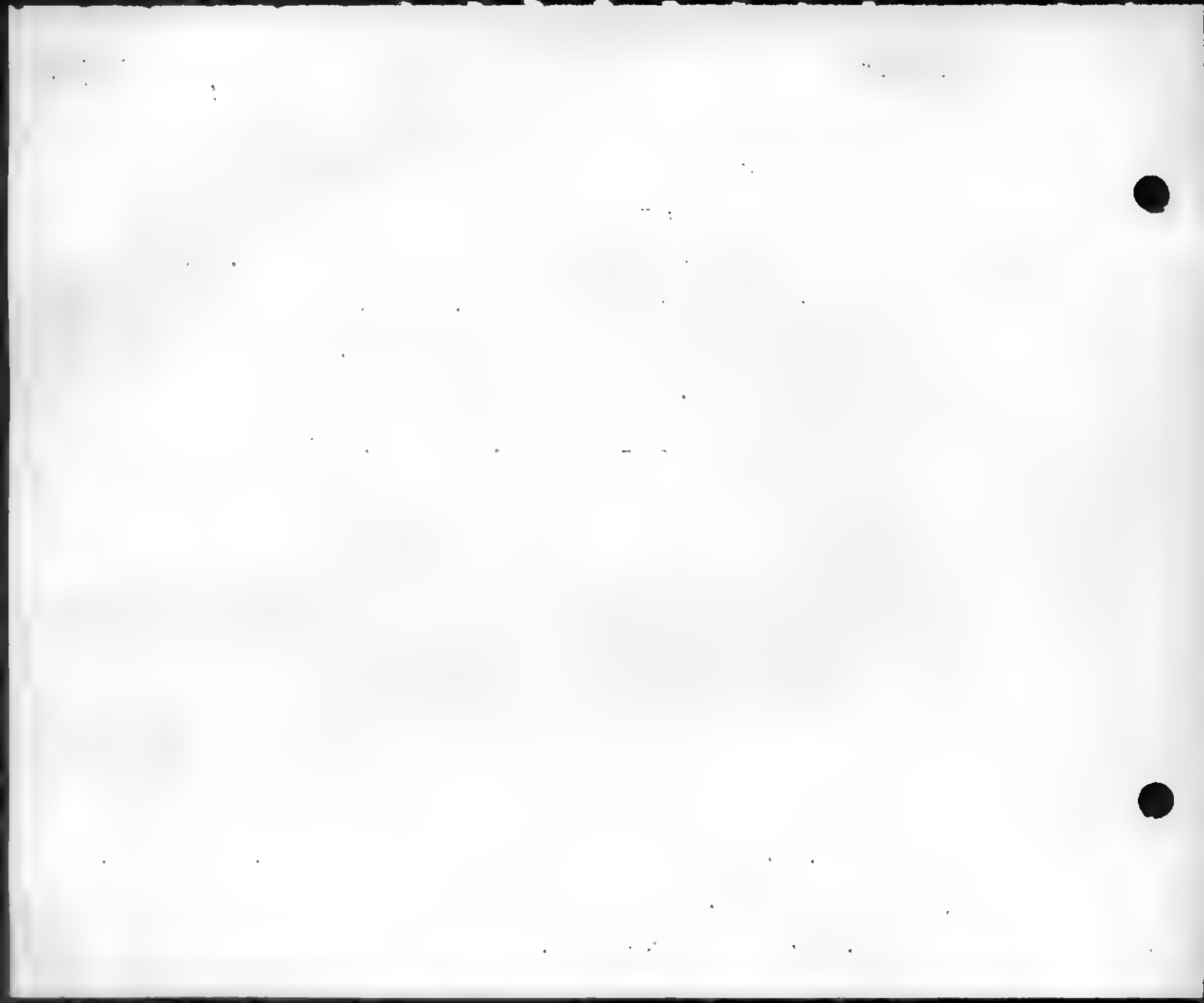
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**15261**

**15260**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>suburban Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4022 Putty Hill Avenue, -36</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>suburban Baltimore</b> d. STREET ADDRESS <b>4022 Putty Hill Avenue, -36</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CELIA</b> Middle <b>FRANKETTA</b> Last <b>HAMILTON</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 16, 1890</b>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Comanche, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Silfies</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Rex</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-3366 D</b>		17. INFORMANT <b>Mrs. Lindsay H. Paul</b>		Address (same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> (b) <b>Acute gastro-enteritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>—</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963, 1962, to Jan 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 19 66</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Geo H. Beck</b>				22b. DATE SIGNED <b>11/27/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. George Beck</b>	
22d. ADDRESS <b>6012 Harford Rd., Balto., Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11/23/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.-Baltimore, Md.-14</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15262

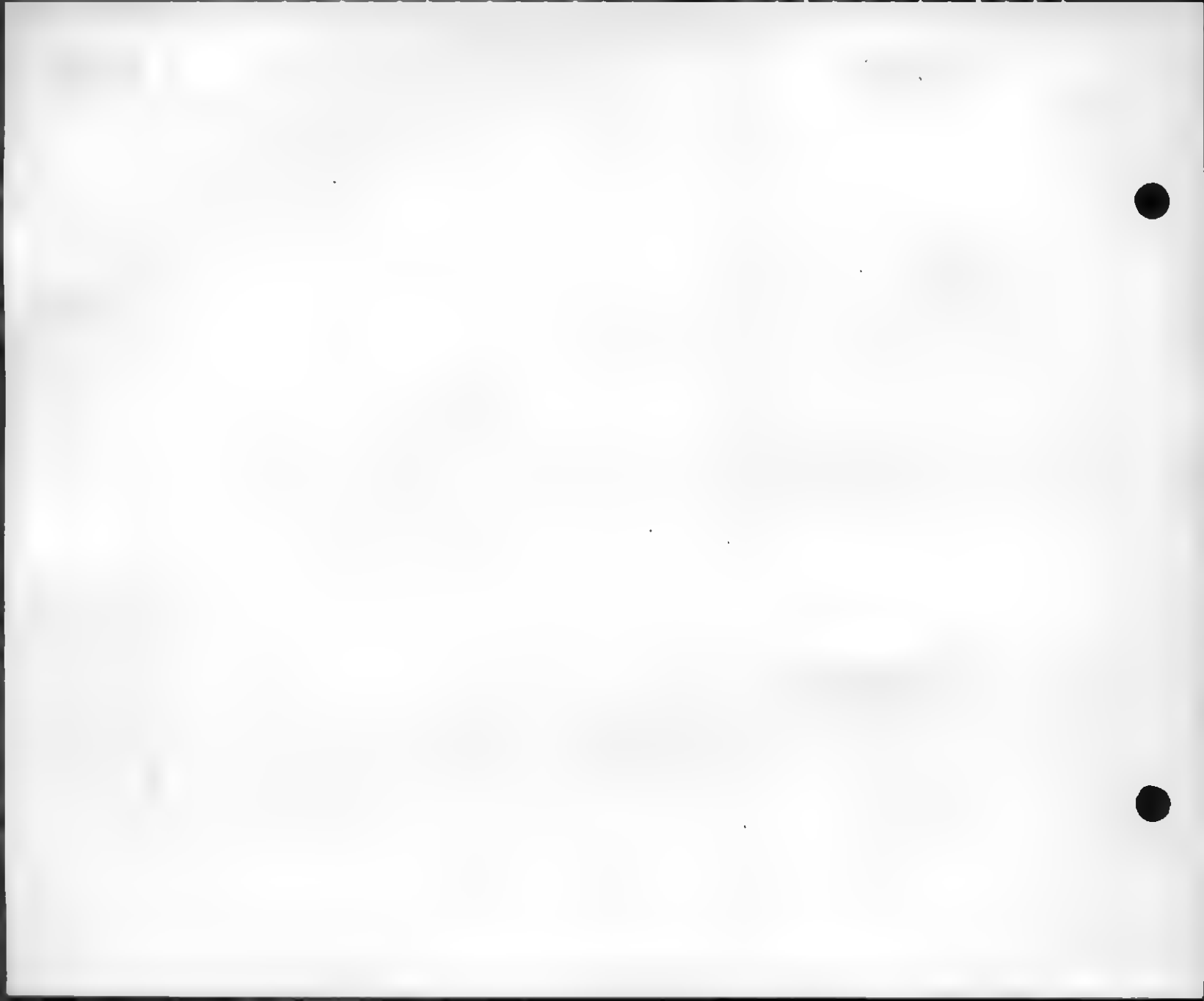
## CERTIFICATE OF DEATH

15261

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALDWIN</u>				c. LENGTH OF STAY IN 1b <u>59 YRS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALDWIN, Md.</u>				d. STREET ADDRESS <u>Box 2 BALDWIN, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 2 BALDWIN, MARYLAND</u>				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER MITCHELL HAMMETT</u>				4. DATE OF DEATH Month Day Year <u>OCT 1 NOV. 6 19 66</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1876</u>	9. AGE (In years last birthday) <u>90 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>medicine</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARY'S Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN L. HAMMETT</u>				14. MOTHER'S MAIDEN NAME <u>JANE BOWEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-48-2427</u>		17. INFORMANT Address <u>MRS MARY HAMMETT Box 2 BALDWIN, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO VASCULAR DISEASE</u> (c) <u>DUE TO CARDIAC FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Y-2</u> <u>1 M</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>11-6</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-5</u> , 19 <u>66</u> and that death occurred at <u>2300AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Edwin Muller</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>S. EDWIN MULLER</u>		22d. ADDRESS <u>1202 ST Paul St Bldg 2</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>PIKESVILLE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Tolson, 1050 YORK ROAD, TOLSON, MARYLAND 21204</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

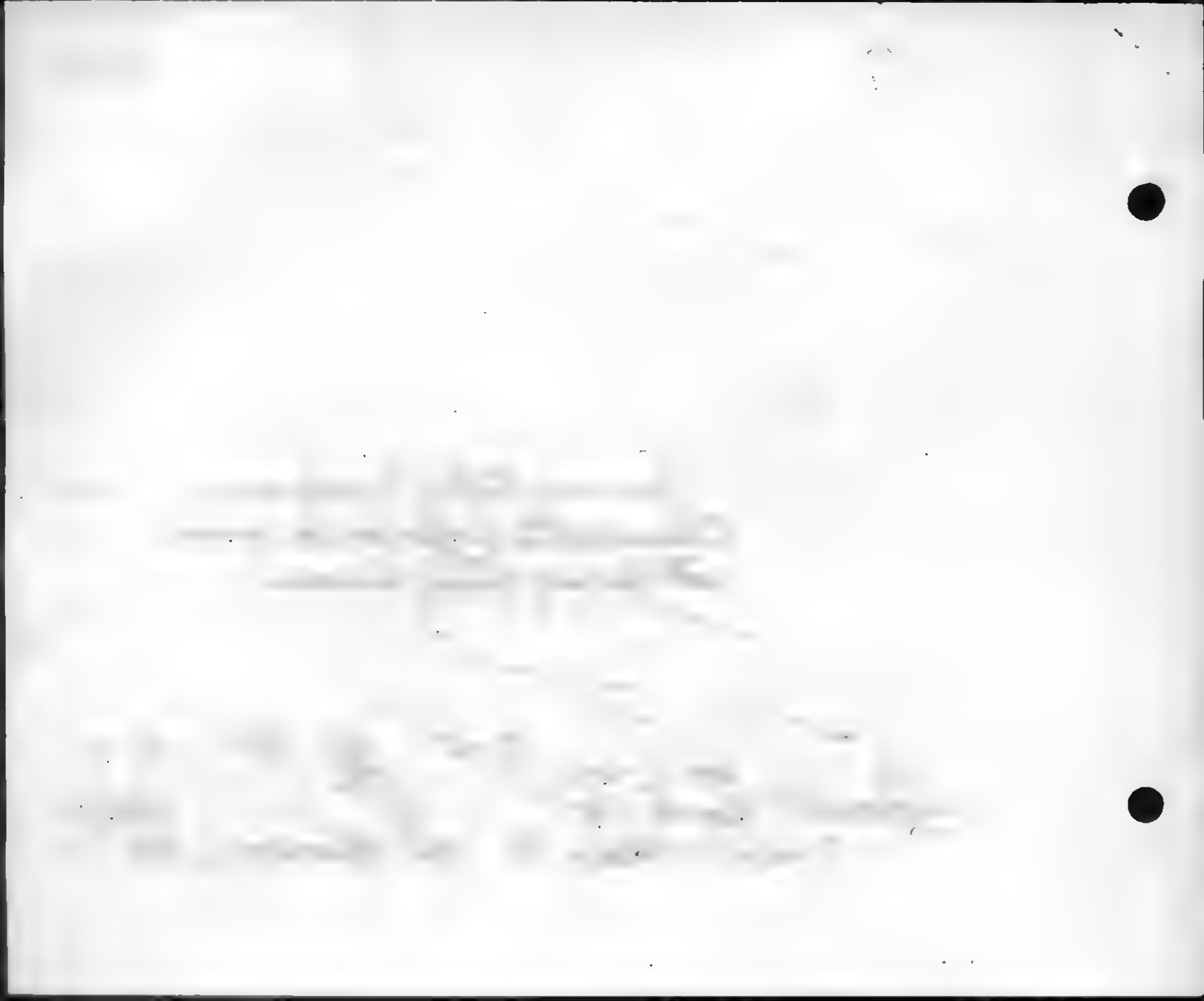


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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15263 CERTIFICATE OF DEATH 15262

1. PLACE OF DEATH a. COUNTY <b>Balto</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
c. LENGTH OF STAY IN 1b <b>26 yrs</b>				d. STREET ADDRESS <b>2526 Wentworth road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2526 Wentworth road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN G HANCOCK</b>				4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 12 1912</b>	
9. AGE (in years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mln.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Erector</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penn</b>	
12. CITIZEN OF WHAT COUNTRY? <b>usa</b>							
13. FATHER'S NAME <b>John S. Hancock</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Bloom</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>577-20-4616</b>		17. INFORMANT <b>Family records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <b>45 yr.</b> DUE TO (b) <b>Atherosclerotic Cardiovascular disease</b> DUE TO <b>with Coronary Artery disease.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>48 hr.</b> <b>5 + yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1963</b> to <b>Nov 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 1 1966</b> and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank T. Kazik</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK T. KAZIK M.D.</b>				22d. ADDRESS <b>9105 HARFORD RD. BALTIMORE, MD 21234</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON</b>				ADDRESS <b>8802 Harford road</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

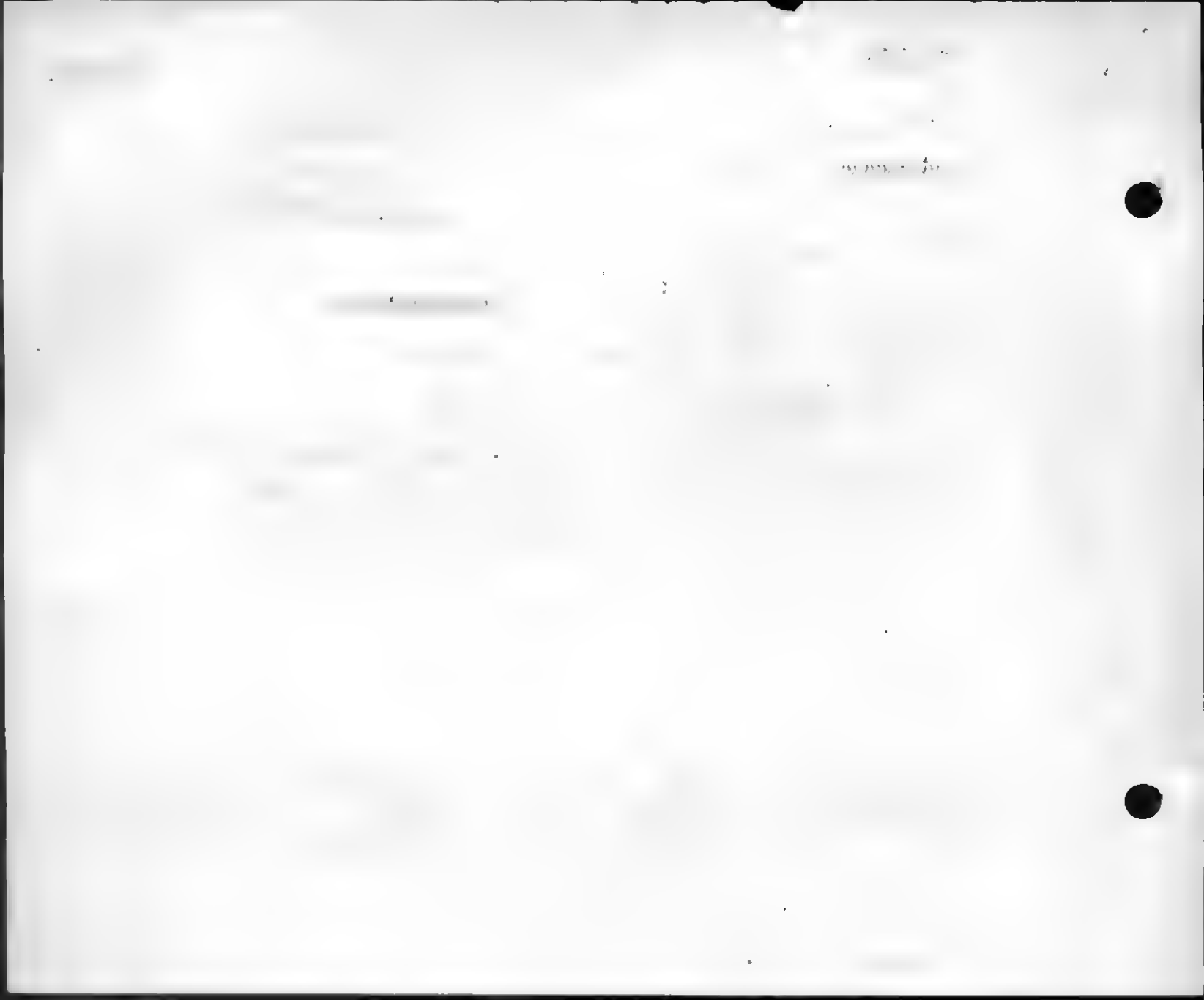


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15264 CERTIFICATE OF DEATH 15263

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FORLEIGH NURSING HOME</b>		d. STREET ADDRESS <b>3623 Seven Mile Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Anna</b> Middle <b>R.</b> Last <b>HANKIN</b>		4. DATE OF DEATH <b>11 19 1966</b> Month <b>11</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>73</b> yrs. 9. AGE (in years last birthday) <b>73</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>MORRIS SCURNICK</b>		14. MOTHER'S MAIDEN NAME <b>Fannie ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-32-0832 A</b>	
17. INFORMANT <b>Mr. Edward Hankin, 3623 Seven Mile Lane</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia + Myocardial Infarction</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> to <b>11/19</b> , 1966, that (I) (we) last saw the deceased alive on <b>11/19</b> , 1966, and that death occurred at <b>4:20</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Leonard Rotz</b>		22b. DATE SIGNED <b>11/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEONARD ROTZ M.D.</b>		22d. ADDRESS <b>11 Slide Ave Balto 8 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Nesina</b>		23d. LOCATION (City, town or county) (State) <b>Rosedale, Maryland</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 REISTERSTOWN</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15265

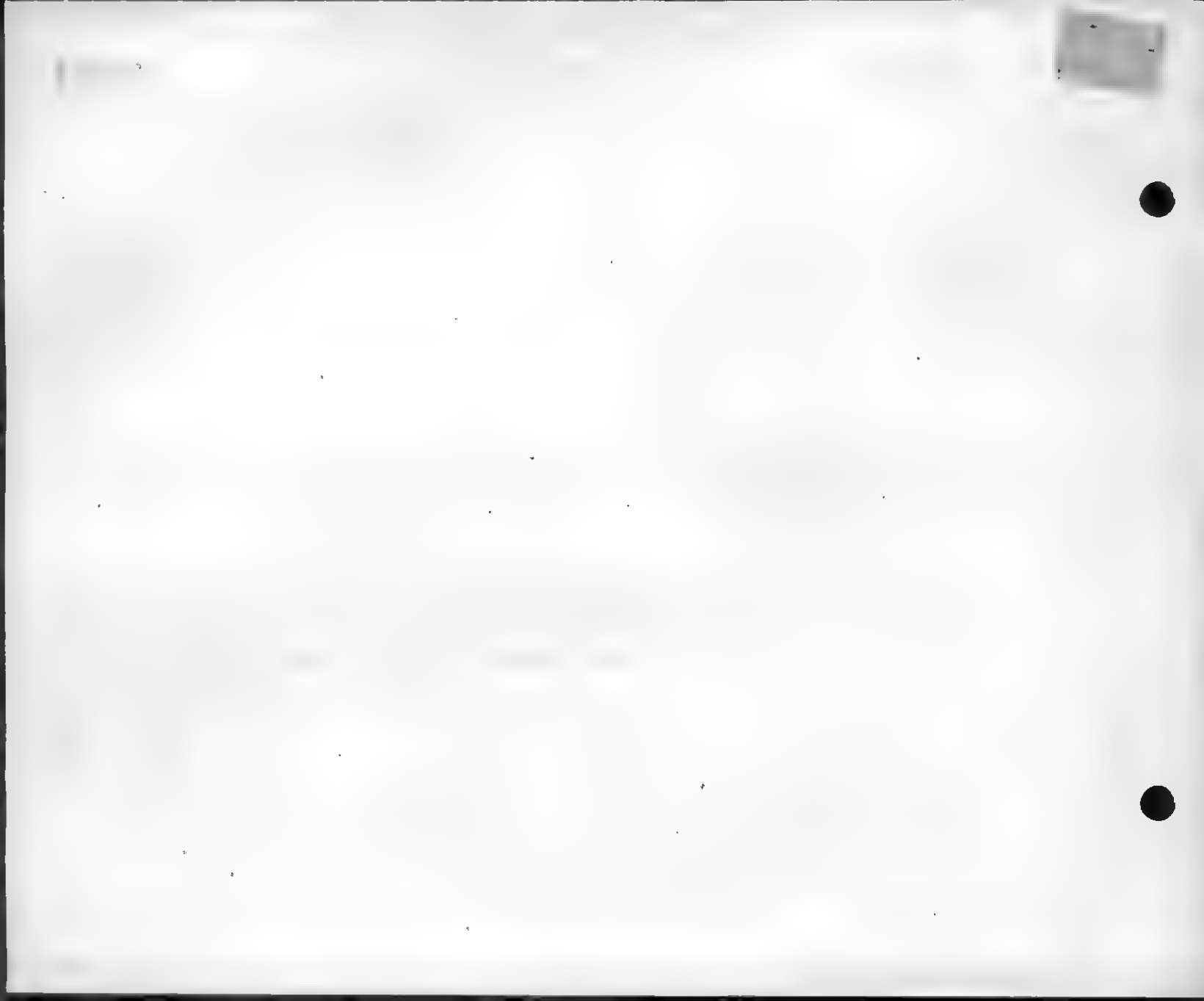
CERTIFICATE OF DEATH

15264

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>520 Academy Road</u>		d. STREET ADDRESS <u>520 Academy Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>J</u> Last <u>Hansely</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3rd</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1903</u>
9. AGE (In years lost birthday) yrs <u>63</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. C T ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Hansely</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Kenneth C Hansely</u>		Address <u>7988 Nolcrest Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Acute</u> TALL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>Nov</u> , 1966, that (I) <u>was</u> last saw the deceased alive on <u>Sept. 30</u> 19 <u>66</u> , and that death occurred at <u>3:30AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leo J. Gaver</u>		22b. DATE SIGNED <u>11/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver</u>		22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 5 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Thomas J Kerry Inc 1601 Hollins St. Balto. Md.</u>		25. REC'D BY REGISTRAR DATE <u>NOV 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

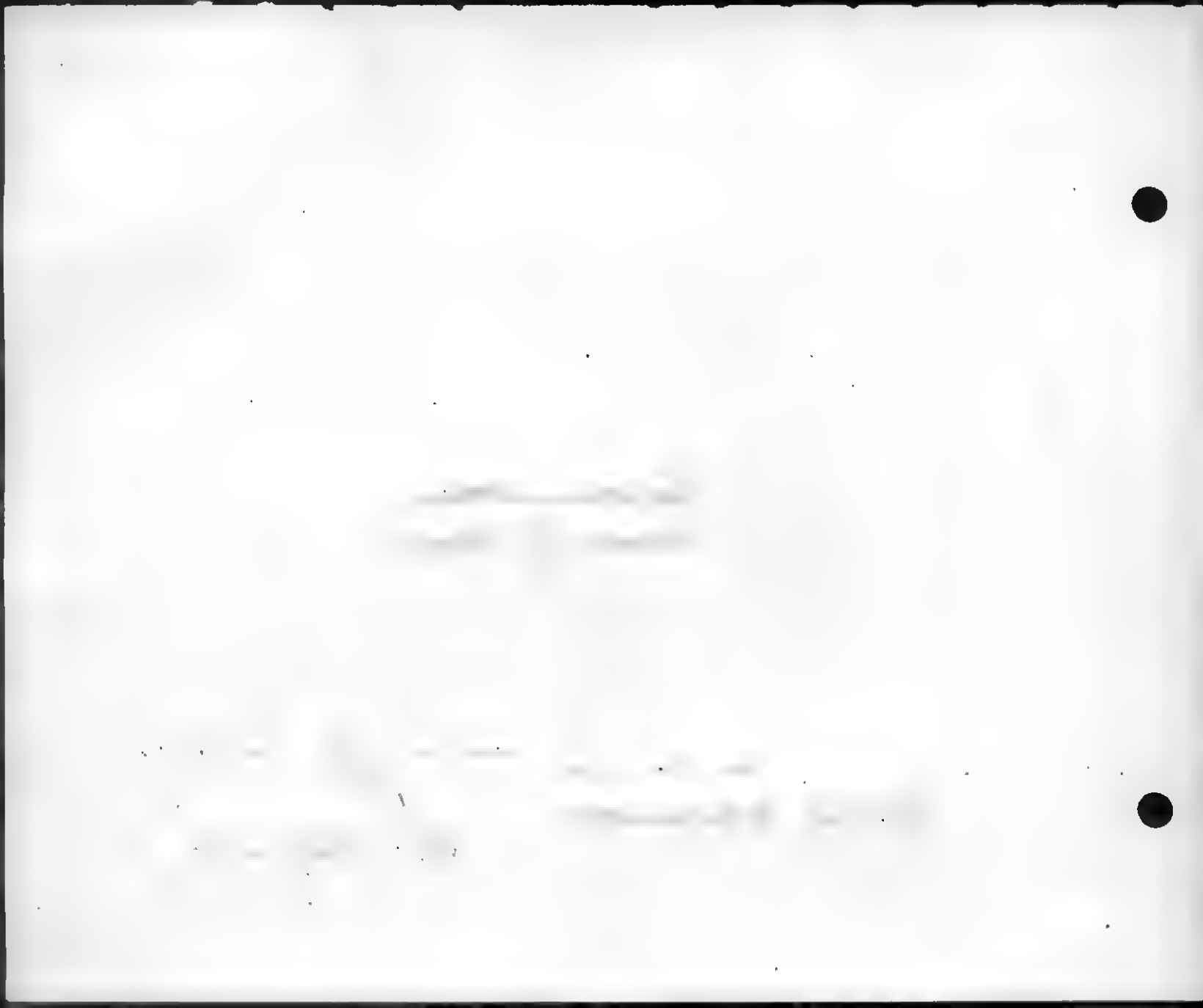


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15266 CERTIFICATE OF DEATH 15265									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STEVENSON</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>STEVENSON</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>VILLA JULIE</u>					d. STREET ADDRESS <u>VALLEY ROAD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SISTER RITA LOYOLA</u> First Middle Last					4. DATE OF DEATH <u>NOV. 27 1966</u> Month Day Year				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 29, 1887</u>		9. AGE (in years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (County & State, of foreign country) <u>MASS.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>JOHN J. HANTZ</u>					14. MOTHER'S MAIDEN NAME <u>THERESA McDONALD.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Sister Mary Margaret - Villa Julie</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Cancer of Breast</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> , 19 <u>66</u> , to <u>Nov 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>66</u> , and that death occurred at <u>6:25</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Harold H Burns MD</u>					22b. DATE SIGNED <u>11-28-1966</u>		22c. PHYSICIAN'S NAME (Type) <u>8106 Harford Rd 34. md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Jessiter, Md.</u>		
24. FUNERAL DIRECTOR <u>Tracy-Cornwall &amp; Son, Catonsville, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15267

## CERTIFICATE OF DEATH

15266

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RS #2</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hampstead Md</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RS #2 Hampstead Md</u> d. STREET ADDRESS <u>Brick Store Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William W HARMON Sr</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>November 28 1966</u>	
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2/24/94</u> <b>9. AGE</b> (In years last birthday) <u>72</u> yrs IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>agventure</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Glenn HARMON</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Florence Alban</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>219-36 2023</u> <b>16. SOCIAL SECURITY NO.</b> <u>219-36 2023</u> <b>17. INFORMANT</b> <u>Russell Harmon</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>100% DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Occlusion</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/8</u> <u>1966</u> <u>to 11-28</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>11-26</u> <u>1966</u> , and that death occurred at <u>7A.M.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Joseph E. Bush</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Joseph E. Bush MD</u>		<b>22b. DATE SIGNED</b> <u>11-28-66</u> <b>22d. ADDRESS</b> <u>HAMPSTEAD MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>11/30/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Salem EUB</u> <b>23d. LOCATION (City, town or county)</b> (State) <u>Balto Co. Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tipton-Eline</u> <b>25a. REC'D BY REGISTRAR</b> <u>DEC 2 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15269

15268

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN b. <b>CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FALLS ROAD near Broadway Road</b>				d. STREET ADDRESS <b>Falls Road near Broadway Rd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BEATRICE MARGIE HARR</b>				4. DATE OF DEATH Month Day Year <b>11 29 1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1928</b>	9. AGE (In years lost birthday) yrs <b>38</b>	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WALTER ALLERD</b>				14. MOTHER'S MAIDEN NAME <b>ELLA (?) ALLERD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> 773X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently shot husband - then went in garage and turned on</b>					
20c. TIME OF INJURY Month Day Year <b>EARLY A.M. 11 29 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Garage - Home</b>	20f. (City or town) <b>Cockeysville Balto.</b>	(County) <b>Md.</b>	(State) <b>Md.</b>	20g. car motor
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 2, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace-Falls Road Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>		22. DATE SIGNED <b>11-29-66</b>
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 5 1966</b>		25b. REGISTRAR'S SIGNATURE 		





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15270

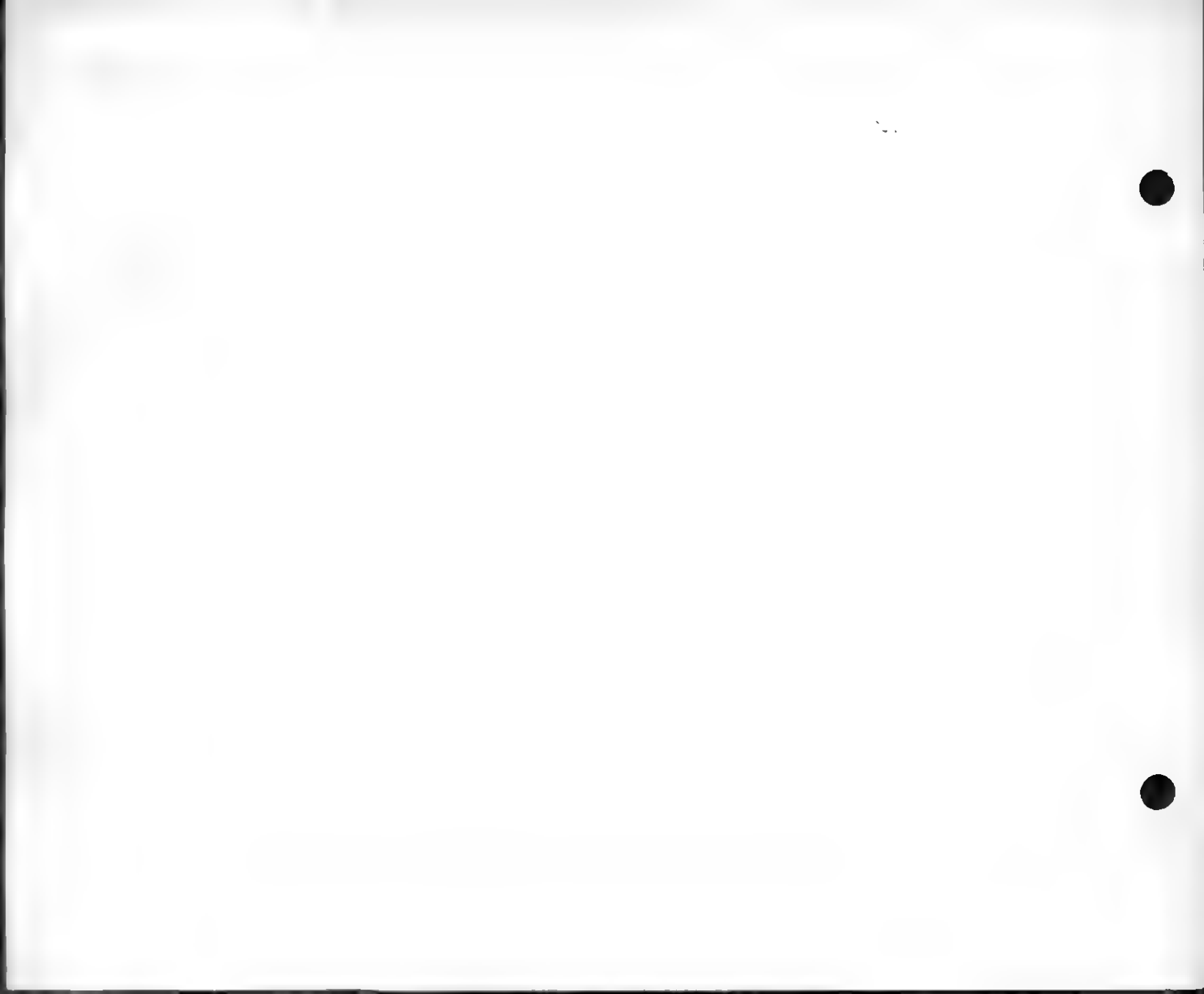
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15269

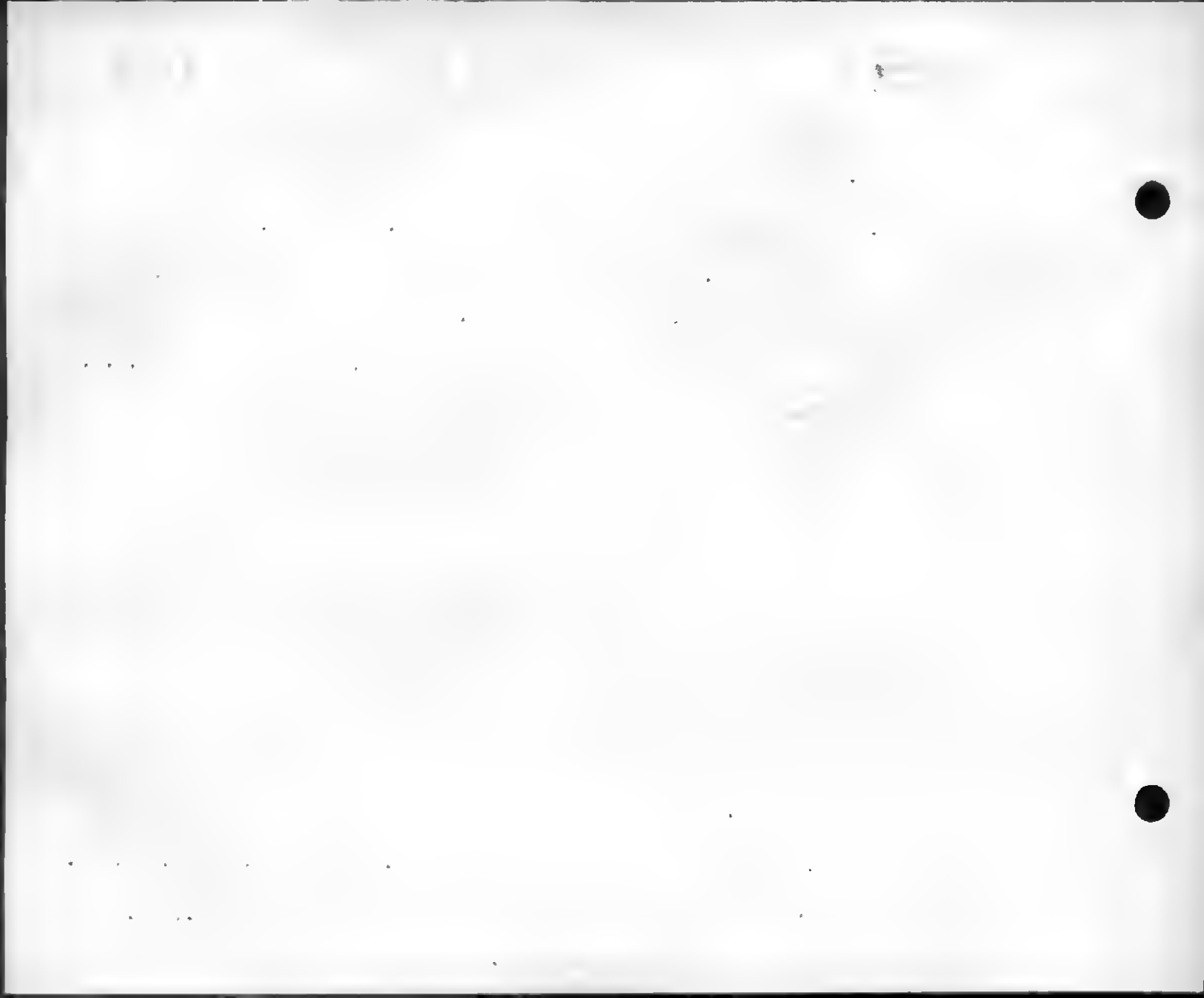
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>Cockeysville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FALLS ROAD near Broadway Road</b>		d. STREET ADDRESS <b>Falls Road near Broadway Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE HERBERT HARR</b>		4 DATE OF DEATH Month Day Year <b>11 29 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAY 21, 1928</b>
9 AGE (In years past birthday) <b>38 yrs</b>		10 UNDER 1 YEAR Months Days Hours Min <b>11 29 1966</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Feed Stores</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner-Operator</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Herbert F. Harr</b>		14 MOTHER'S MAIDEN NAME <b>Ethel Jones</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No None</b>		16 SOCIAL SECURITY NO <b>Family Records</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY <b>951X IMMEDIATE CAUSE (a) Gunshot wounds of chest involving lungs and liver</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Apparently shot by wife during altercation</b>	
20c. TIME OF INJURY Month Day Year <b>Early Morning 11 29 1966</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cockeysville Balto. Maryland</b>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11-29-66</b>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 2, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace-Falls Rd. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>
24. FUNERAL DIRECTOR ADDRESS <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 2 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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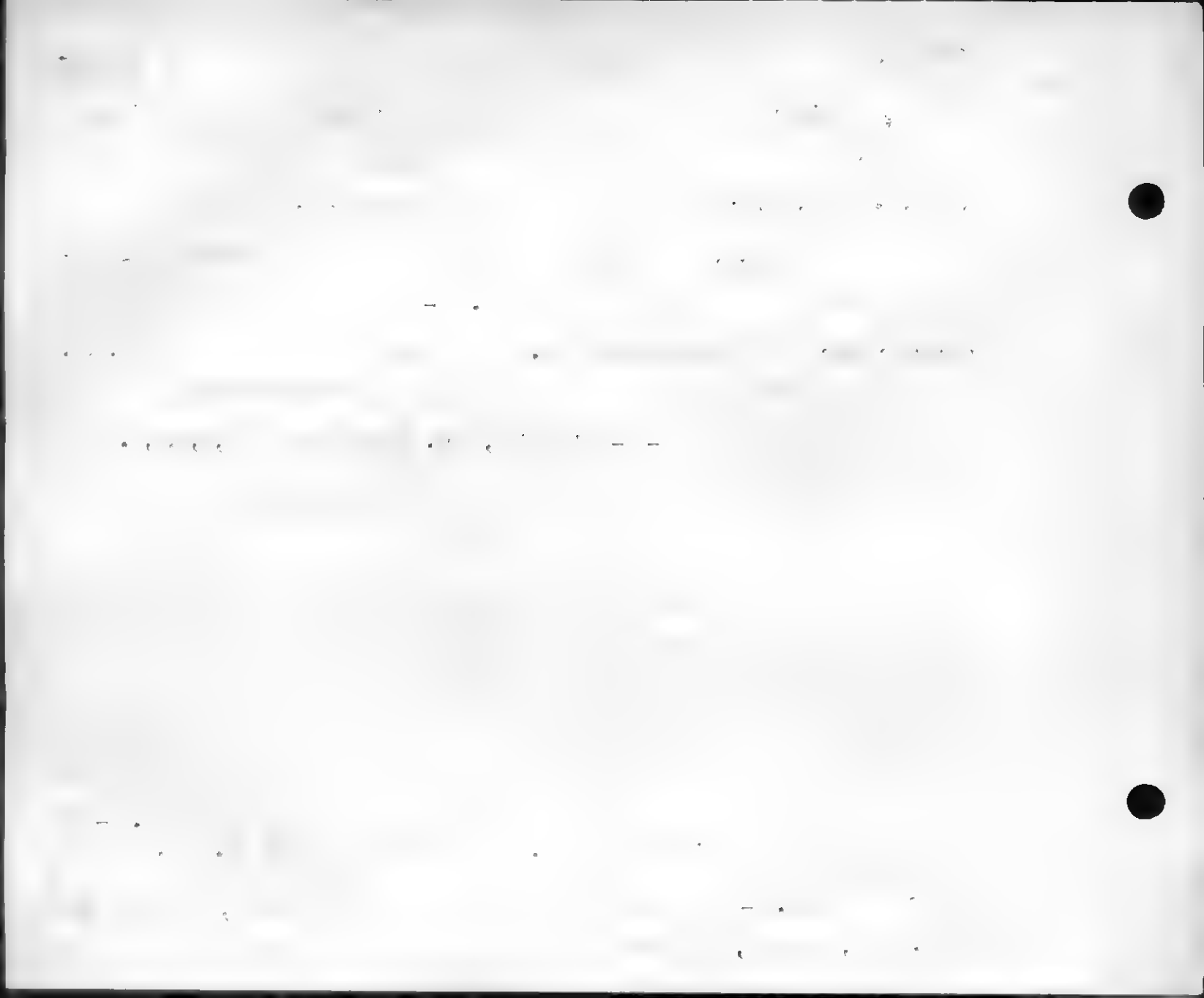
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15268

15267

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>103 Dundalk Avenue 21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Stephens</b> Last <b>Haroth</b>			4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29 1908</b>	9. AGE (In years last birthday) <b>57</b> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soectrographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Emil Robert Haroth</b>			14. MOTHER'S MAIDEN NAME <b>Bertha Frances Kratzmeier</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-9373</b>		17. INFORMANT Address <b>Wife, Mrs. Mary Haroth, # 2, a, b, c, d.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lung Cancer</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from <b>Oct 28, 1966</b> to <b>Nov 6, 1966</b> , that (1) (we) last saw the deceased alive on <b>Nov 6, 1966</b> , and that death occurred at <b>1:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Chili Chin Shih</b>			22b. DATE SIGNED <b>Nov. 6-1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>Chili Chin Shih</b>		M.D. <b>M.D.</b>	22d. ADDRESS <b>6701 North Charles St. Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 9-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland 21224</b>				
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>			25a. REC'D BY REGISTRAR <b>NOV 10 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**15272** **CERTIFICATE OF DEATH** **15271**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2533 Farrington Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anne Helzner</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Israel Glass</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Goldberg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mr. Harry Helzner, 2533 Farrington Road #9</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage Sept. 24, 1966</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>62</u> , to <u>Nov. 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 14</u> , 19 <u>66</u> , and that death occurred at <u>1p</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis R. Maser</u>				22b. DATE SIGNED <u>11-15-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Louis Maser</u>	
22d. ADDRESS <u>2724 Smith Avenue</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mikro Kodesh Beth Israel</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown RD</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>NOV 17 1966</u>			

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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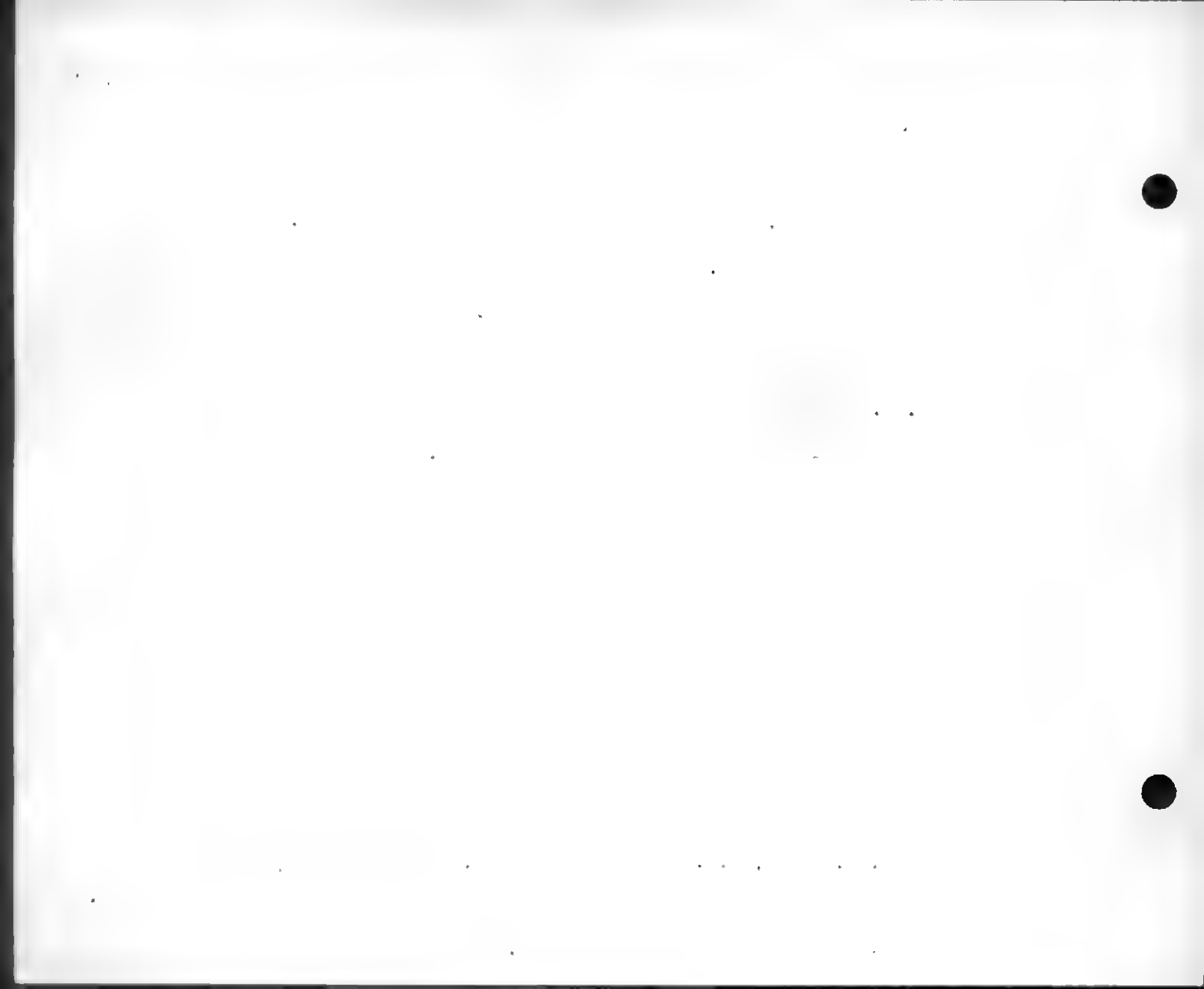
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15272

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c LENGTH OF STAY IN 1b <b>13.1</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1015 Eastern Ave.</b>		d STREET ADDRESS <b>1015 Eastern Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>Madie M. Hess</b>		4 DATE OF DEATH <b>November 10, 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 23, 1906</b>
9 AGE (In years last birthday) <b>59</b> yrs	10 UNDER 1 YEAR Months	11 UNDER 1 YEAR Days	12 UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>W. R. Shiflett</b>		14. MOTHER'S MAIDEN NAME <b>Lodie Morris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212 24 4385</b>	
17. INFORMANT <b>William M. Hess</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>H-S-C-V-Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>As above</b>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		22. DATE SIGNED <b>11/10/66</b>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D. 6800 Mornington Rd. Dundalk, Md.</b>		23. NAME OF CEMETERY OR CREMATORY <b>Preddy-Teague Funeral Home</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>11/12/66</b>	23c. LOCATION (City or town) (County) (State) <b>Charlottesville, Va.</b>	23d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
24. FUNERAL DIRECTOR'S NAME (Type) <b>Bruzdzinski Funeral Home 1407 Eastern Ave.</b>		25. REC'D BY REGISTRAR <b>NOV 14 1966</b>	



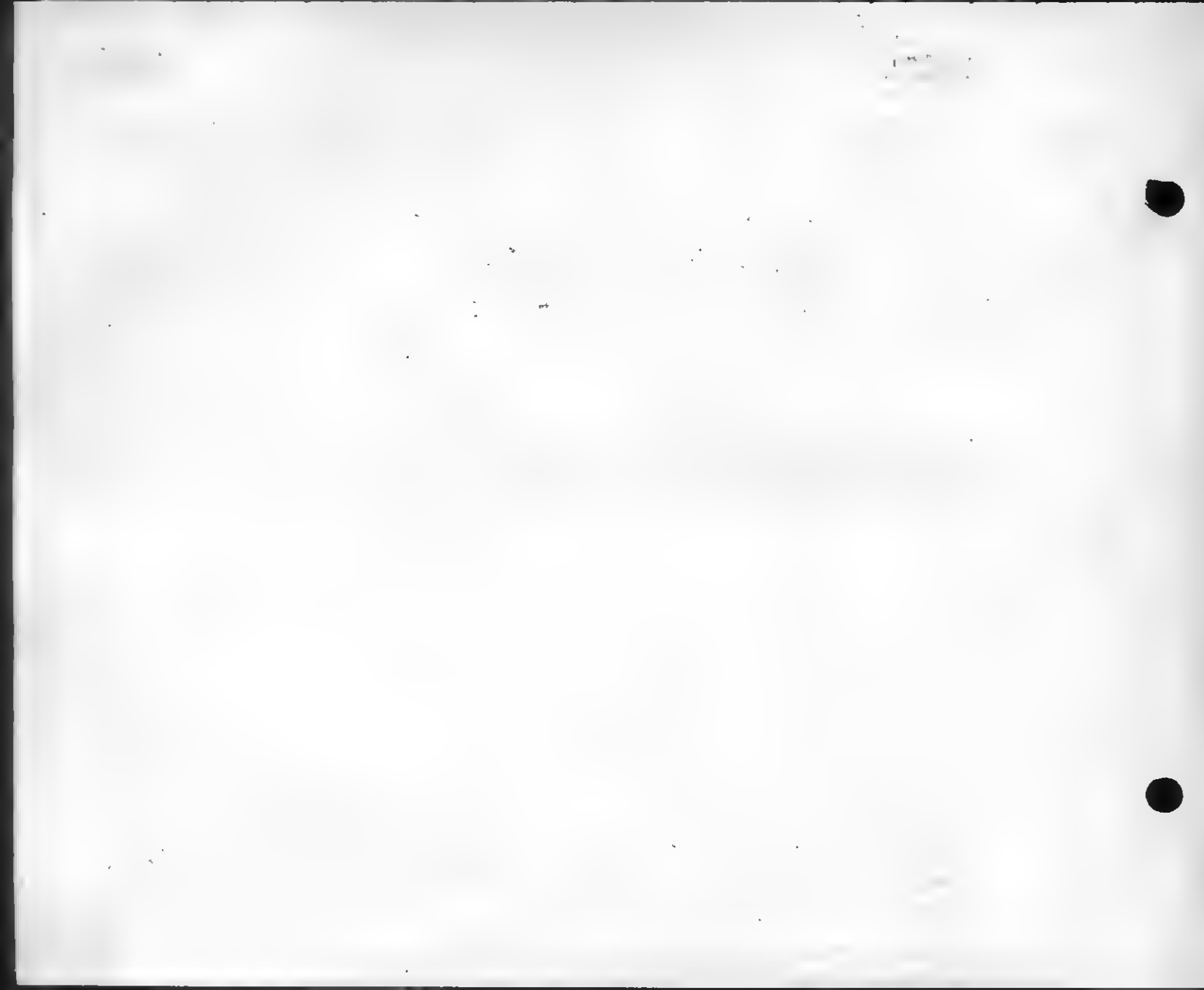
FOR STATE  
HEALTH DEPT.

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3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
152774 152773									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN ID <b>30 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2934 SOLLERS POINT ROAD</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MD. 21222</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 21222</b> d. STREET ADDRESS <b>2934 SOLLERS PT. RD.</b>				
3. NAME OF DECEASED (Type or print) <b>ROBERT GARRISON HILTON</b>					4. DATE OF DEATH <b>NOV. 13, 1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 10, 1902</b>		9. AGE (In years last birthday) <b>63</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRIAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN H. HILTON</b>					14. MOTHER'S MAIDEN NAME <b>MARDELINE GINGELL</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>					16. SOCIAL SECURITY NO. <b>217-05-6934</b>				
17. INFORMANT <b>RACHEL D. HALL - DUNDALK, MD</b>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DUE TO</b> (c) <b>DUE TO</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>No</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>M. B. Davis</b>					22. DATE SIGNED <b>11/14/1966</b>				
EXAMINER'S NAME (Type) <b>M. B. DAVIS - 6800 MCR WING TOW</b>					DEPUTY MEDICAL EXAMINER <b>REL. DUNDALK</b>				
23a. BURIAL, CREMATION, or other (Specify) <b>CREMATION</b>			23b. DATE OF THE DEED <b>11/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. MD</b>		
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Dundalk, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 16 1966</b>				
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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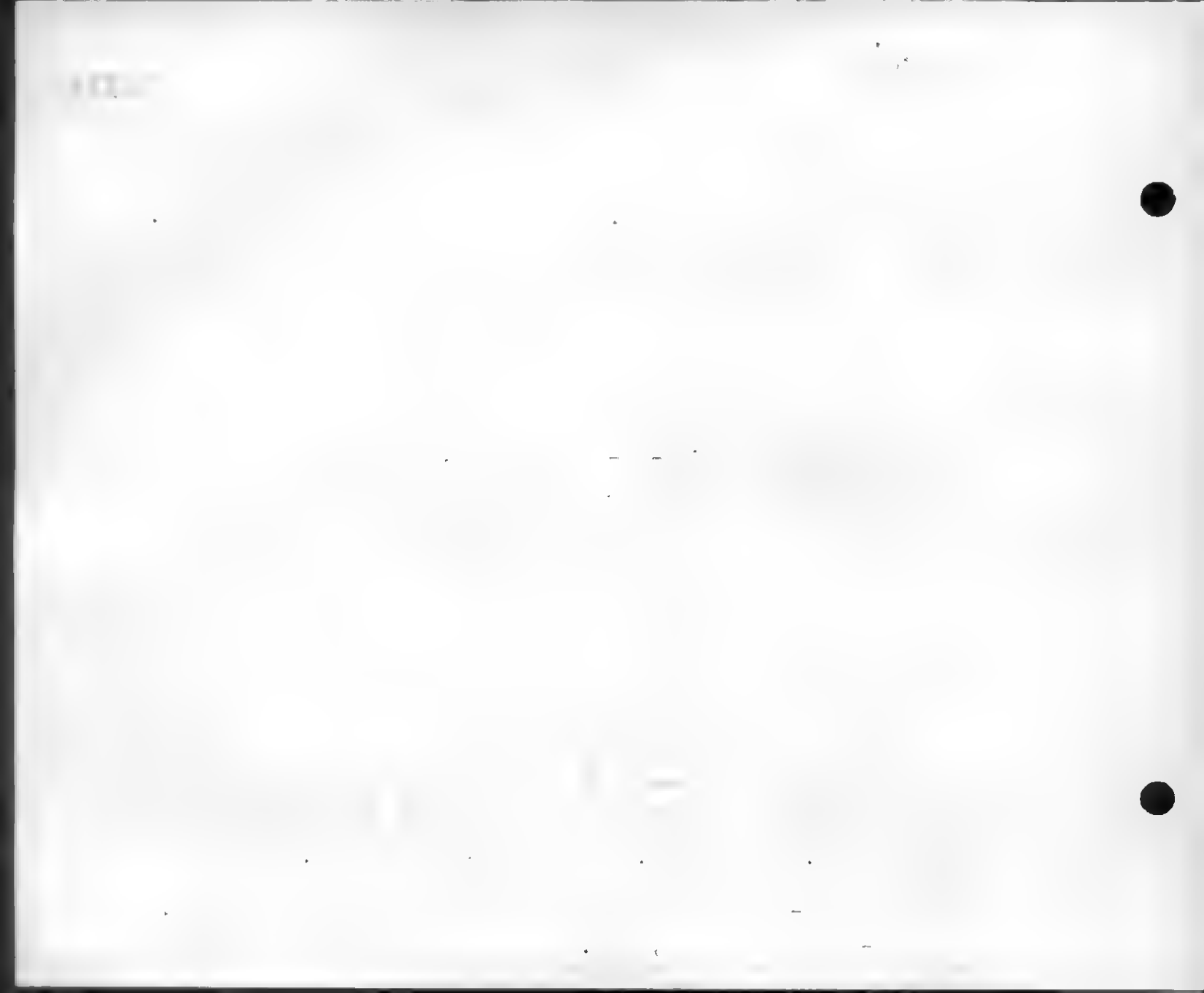
15275

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15274

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Rodgers Forge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>228 Rodgers Forge Rd.</b>		e. STREET ADDRESS <b>228 Rodgers Forge Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Lura Belle Himes</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 2, 1883</b>
9 AGE (In years last birthday) <b>83</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry T. Scholl</b>		14. MOTHER'S MAIDEN NAME <b>Nellie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-48-8540</b>	
17. INFORMANT <b>John F. Himes</b>		Address <b>7306 Park Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1966</b> , to <b>Nov 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 10, 1966</b> , and that death occurred at <b>7 P.M.</b> from causes on and on the date stated above			
22a. SIGNATURE <b>Lawrence C. Post</b>		22b. DATE SIGNED <b>11/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lawrence C. Post</b>		22d. ADDRESS <b>6508 York Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-14-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>NOV 14 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

15276

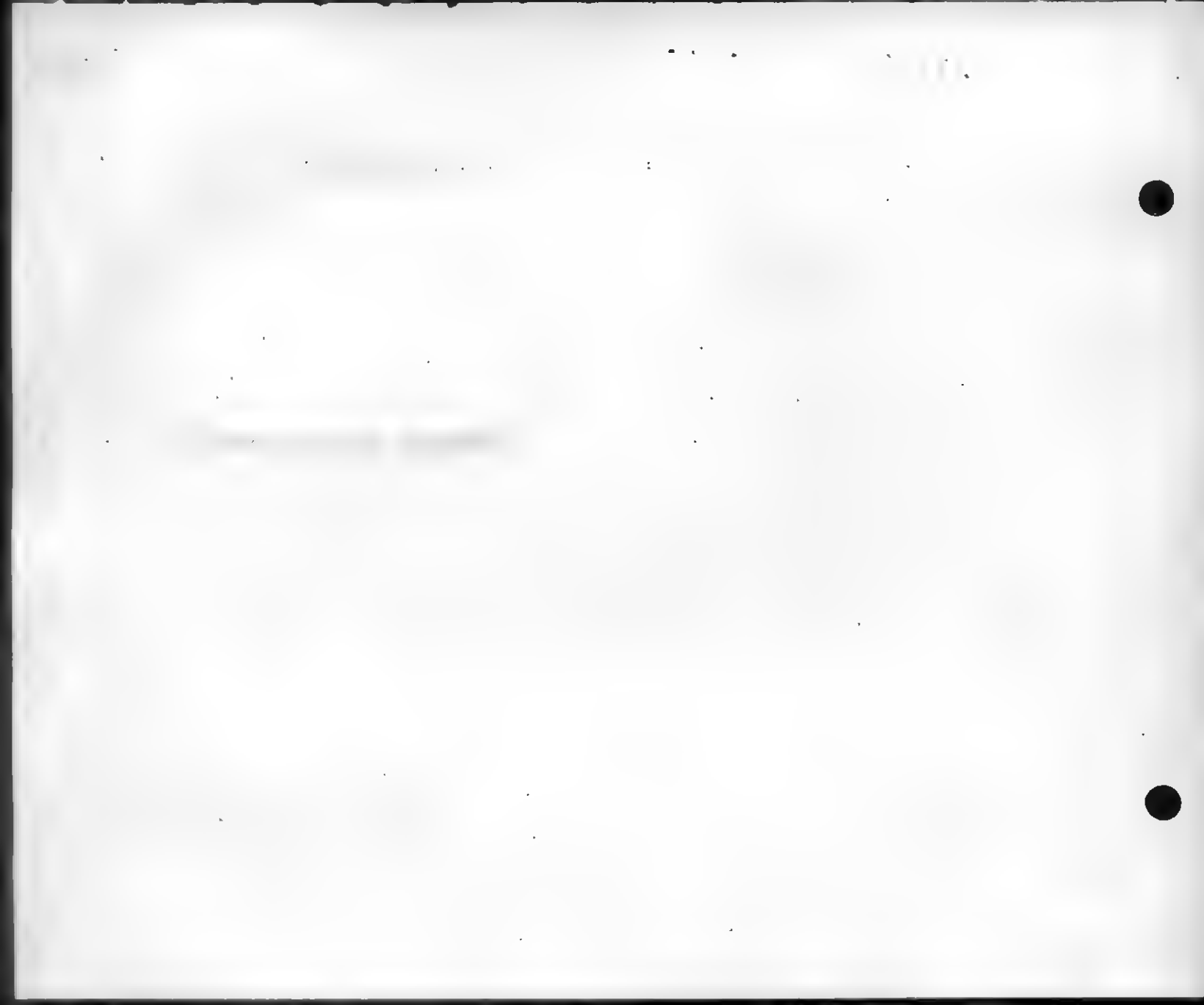
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15275

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS TOWN</u>				c. LENGTH OF STAY IN ID <u>15 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp.</u>				e. STREET ADDRESS <u>3209 DOYRON CT</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>Hitchcock</u>				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-2-84</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILWAY EXPRESS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE B HITCHCOCK</u>				14. MOTHER'S MAIDEN NAME <u>MARY E MALONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>714-05-6855</u>		17. INFORMANT <u>DONALD HITCHCOCK</u>		Address <u>3209 DOYRON CT BALTO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>MI</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>METASTATIC CA TO LUNGS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-2-</u> , 19 <u>66</u> , to <u>11-15-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-15-</u> 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Milton Scheinoff</u>				22b. DATE SIGNED <u>11-15-66</u>		22c. PHYSICIAN'S NAME (Type) <u>DR. MILTON SCHEINOFF</u>	
22d. ADDRESS <u>BALTO - COUNTY MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		23d. LOCATION (City, town or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Foring Byers</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>8728 Liberty Rd</u>				DATE <u>NOV 17 1966</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15277

## CERTIFICATE OF DEATH

15276

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c LENGTH OF STAY IN 1b <b>03.1</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>7414 Park Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Martin</b> First Middle Last <b>HOFFMAN</b>		4. DATE OF DEATH Month Day Year <b>November 12, 1966</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 11, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <b>1 1/2</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Donald H. Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Ellen M. Yeager</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Donald H. Hoffman</b>		Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>11/11/</b> , 19 <b>66</b> , to <b>11/12/</b> , 1966, that (I) (we) last saw the deceased alive on <b>11/12/</b> 19 <b>66</b> , and that death occurred at <b>10:55M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Jose Aguto</b>		22b. DATE SIGNED <b>November 12, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jose Aguto, M.D.</b>		22d. ADDRESS <b>6762 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>11-14-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

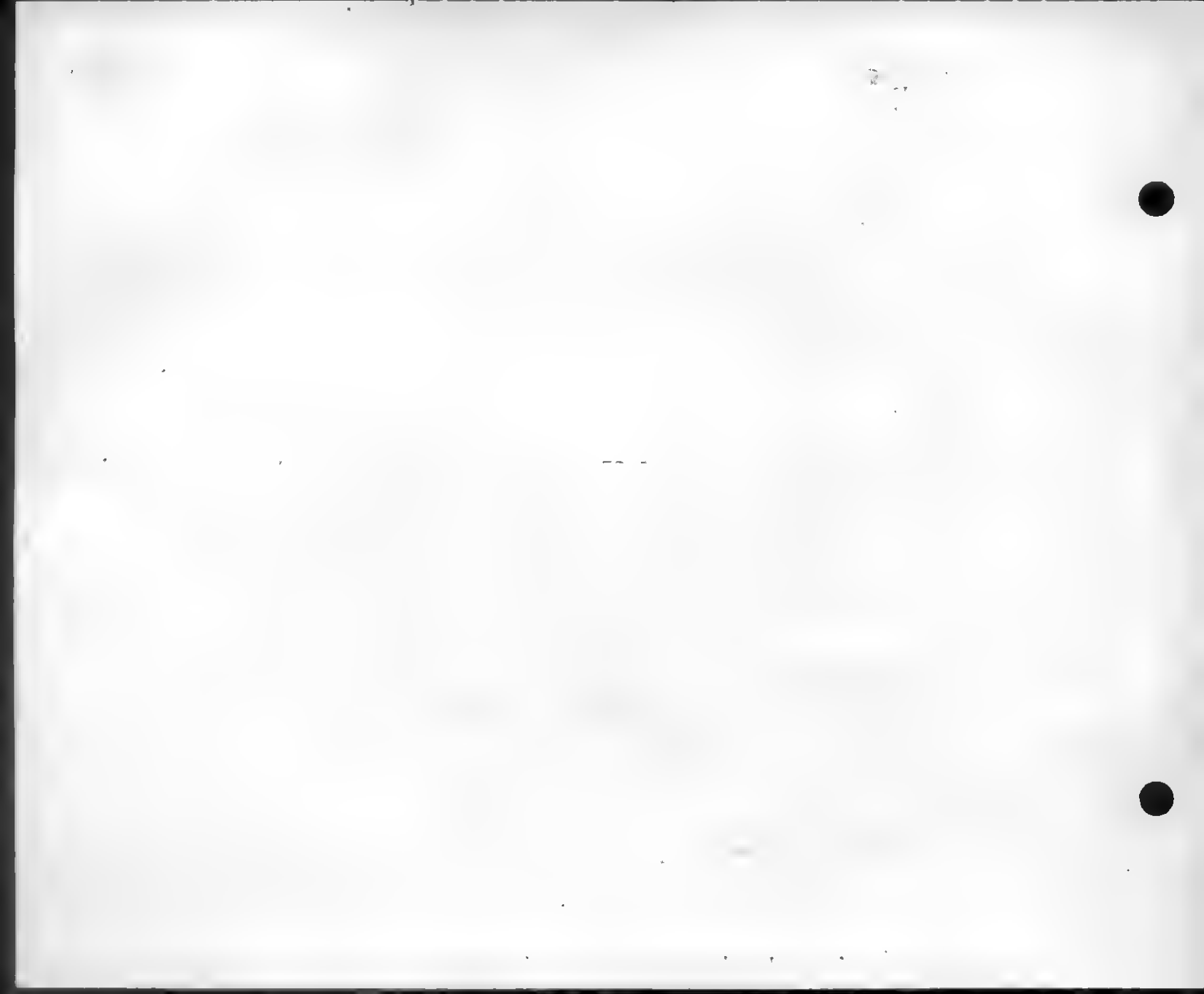
## CERTIFICATE OF DEATH

15278

15277

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b> d. STREET ADDRESS <b>5405 Loch Raven Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First <b>Julia</b> Middle <b>Hoffmayer</b> Last <b>Hoffmayer</b> <b>(Sister Mary Basil)</b>			<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>1</b> Year <b>1966</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-24-89</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Religious</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Philadelphia, Pa.</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Frederick Hoffmayer</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Caroline Goettling</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>	<b>17. INFORMANT</b> Address <b>Sister Wilhelmina SSND, Baltimore, Md. 21212</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction left ventricle.</b> DUE TO (b) <b>Arteriosclerosis coronary arteries, severe.</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.	<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that</b> <del>he</del> <b>(this hospital)</b> <b>attended the deceased from</b> <b>October 23, 1966, to November 1, 1966,</b> <b>that</b> <del>he</del> <b>(we)</b> <b>last saw the deceased alive on</b> <b>November 1, 1966,</b> <b>and that death occurred</b> <b>at 6:00AM,</b> <b>from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 			<b>22b. DATE SIGNED</b> <b>November 1, 1966</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>M.S. Cockburn, M.D.</b>		
<b>22d. ADDRESS</b> <b>7620 York Rd., Baltimore, Md. 21204</b>			<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input checked="" type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>11/3/1966</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Notch Cliff</b>	<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Glen Arm, Maryland</b>				
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd. 21214</b>			<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 7 1966</b>	<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15279

CERTIFICATE OF DEATH

15278

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>148 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d STREET ADDRESS <b>431 ORIOLE AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>--</b> Last <b>HOHBINE</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 31, 1891</b>
9 AGE (In years last birthday) yrs <b>75</b>		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL COMPANY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD HOHBINE</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA CRIST</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16 SOCIAL SECURITY NO <b>212 01 91 80</b>	
17 INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA, PRIMARY SITE UNKNOWN</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/22/66</b> , 19____, to <b>11/17/66</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/17/66</b> , 19____, and that death occurred at <b>1:00A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>11/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-21-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>		25a. REC'D BY REGISTRAR <b>CHARLES S. ZEILER FUNERAL HOME NO. 2</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Zeiler</i>		DATE <b>NOV 22 1966</b>	
6000 Bk Eastern Ave. Baltimore, Md.			

well

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

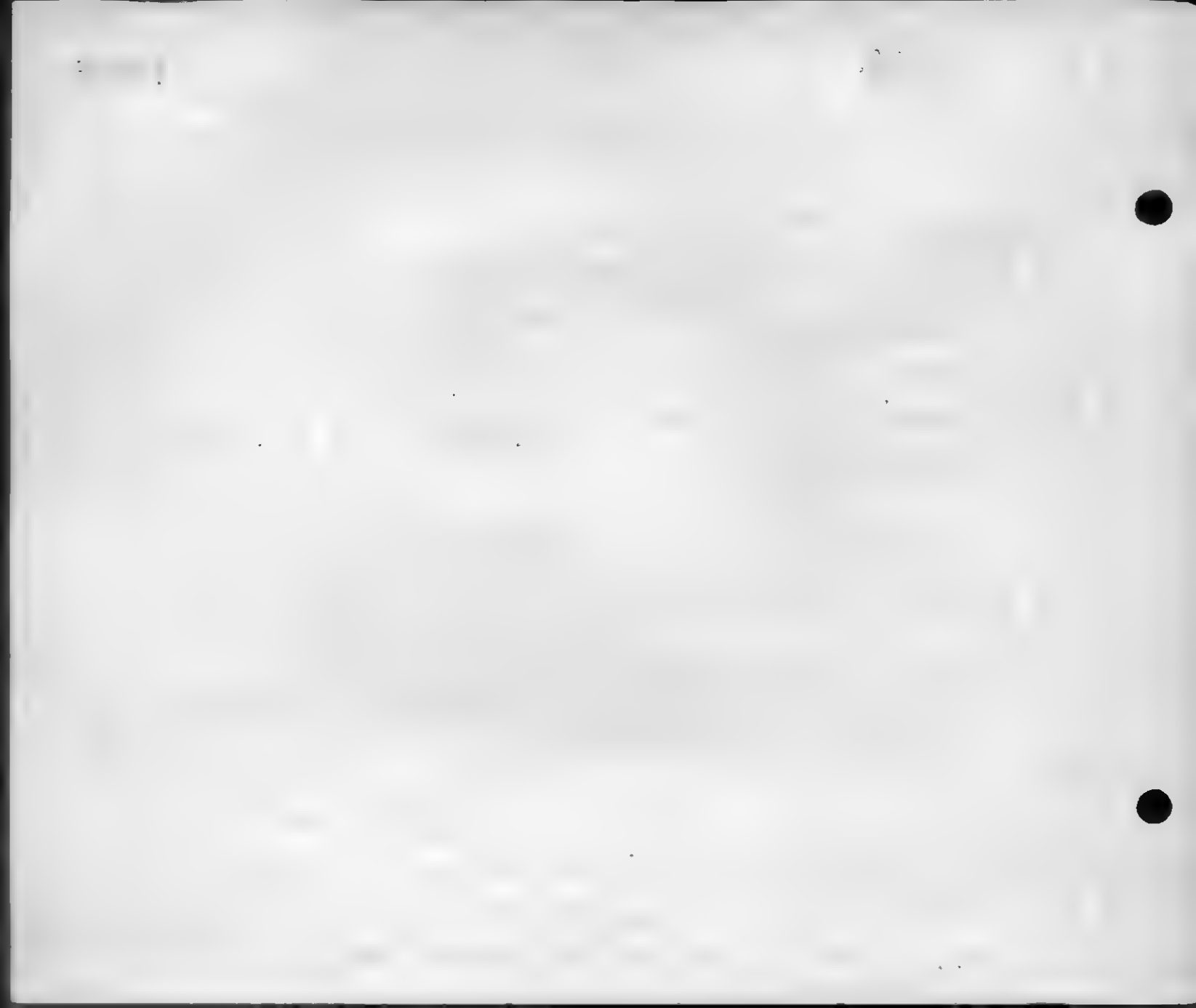
15280

## CERTIFICATE OF DEATH

15279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowson</u> c. LENGTH OF STAY IN TB <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>"Mellie Morris" ic.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>2121</u> d. STREET ADDRESS _____			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Blanche Patterson Honkins</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>19</u> Year <u>1966</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <u>Aug. 14, 1881</u>	<b>9. AGE</b> (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>1001 - 1001 - 1001</u>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>1001 - 1001 - 1001</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>George W. Patterson</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Louisa Grace</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____		<b>16. SOCIAL SECURITY NO.</b> <u>115-10-6000</u>		<b>17. INFORMANT</b> <u>Mrs. Marjorie Michel</u> Address <u>same address as above</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corman's Anemia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____	<b>20f. (City or town)</b> _____ (County) _____ (State) _____				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct. 22, 1966</u> <b>to</b> <u>Nov. 19, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Nov. 19, 1966</u> <b>and that death occurred at</b> <u>11:00 A.M.</u> <b>from the causes and on the date stated above</b>							
<b>22a. SIGNATURE</b> <u>Robert J. Malcom</u>		<b>22b. DATE SIGNED</b> _____		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert J. Malcom</u>			
<b>22d. ADDRESS</b> _____		<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>M.D.</b> <input checked="" type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/11/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Druid Ridge Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Pikesville, Md.</u>		(State) _____					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Tubner &amp; Sons</u>		<b>24a. ADDRESS</b> <u>Balto, Md. north 20th</u>		<b>24b. REC'D BY REGISTRAR</b> DATE <u>NOV 14 1966</u>			
<b>24c. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		_____					





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15281

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15281

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>N. Carolina</u> b. COUNTY <u>Rockingham</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>3 WKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>128 HAMPSHIRE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Hopper</u>		4. DATE DEATH <u>11</u> Month <u>4</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17-1877</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>UNK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Archie Hopper</u>		14. MOTHER'S MAIDEN NAME <u>Joyce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>246-14-9322</u>	
17. INFORMANT <u>Richard Hopper</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V-DISEASE</u> DUE TO (c) <u>Serility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CA Hip + Right knee</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS <u>6800 MORNINGTON BALTO. MD. 22</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Nov. 4th-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ELLIS BORO</u>		23d. LOCATION (City or Town) (County) (State) <u>STONEVILLE N.C.</u>	
24. FUNERAL DIRECTOR <u>J. G. Connelly Sons</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	
ADDRESS <u>300 MACE (2)</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

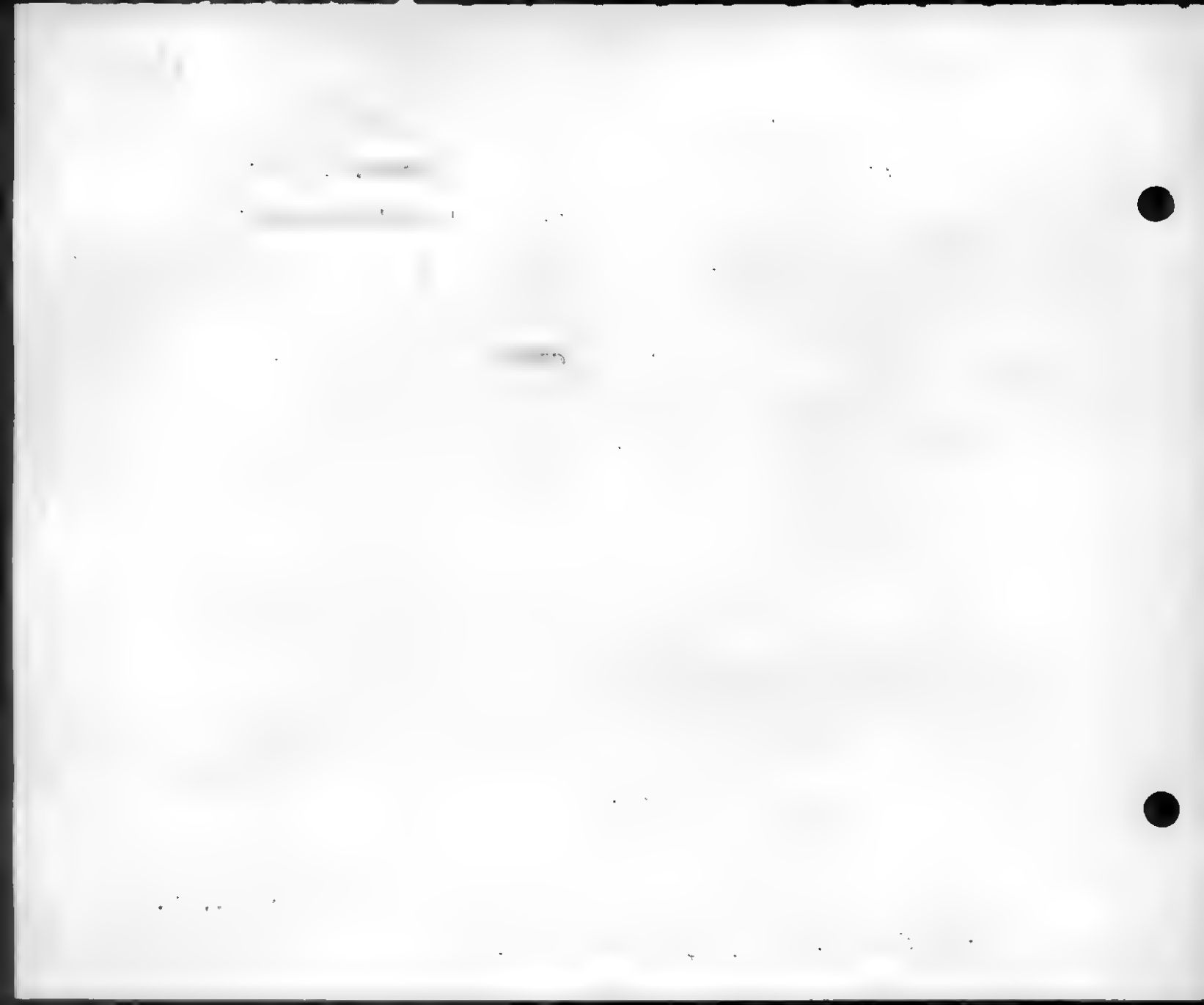


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15282 CERTIFICATE OF DEATH 15281

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ESSEX, MARYLAND 21221</b>	
		f. STREET ADDRESS <b>1 Louella Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES JOSEPH HORNER</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-13</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE COUNTY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>	
14. FATHER'S NAME <b>CHARLES JOSEPH HORNER SR.</b>		15. MOTHER'S MAIDEN NAME <b>PEACOCK</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		17. SOCIAL SECURITY NO. <b>213-03-1846</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastasis</b> DUE TO (b) <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> DUE TO (c) <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 4, 1966</b> to <b>NOV 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>NOV 10, 1966</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Mario B. Ines</b>		22b. DATE SIGNED <b>11-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARIO B. INES M.D.</b>		22d. ADDRESS <b>GP MR. BALTO. MD 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Bruzdziński</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>Funeral Home 1407 Eastern Ave. 21</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15283

CERTIFICATE OF DEATH

15282

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		d. STREET ADDRESS <b>234 Warren Rd. &amp; Howard Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Phyllis</b> Middle <b>M.</b> Last <b>HOWARD</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1897</b>
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James John Milway</b>		14. MOTHER'S MAIDEN NAME <b>Anna Carroll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>congestive heart failure</b> DUE TO (c) <b>arteriosclerotic hypertensive cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebro-vascular accident</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>October 13, 1966</b> , to <b>November 15, 1966</b> that <b>4</b> (we) last saw the deceased alive on <b>November 15, 1966</b> , and that death occurred at <b>4:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		22b. DATE SIGNED <b>Nov. 15, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Road, 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 18, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Cockeysville, Maryland</b>
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15283											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>✓</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>						c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. JOSEPH HOSPITAL</b>						d. STREET ADDRESS <b>418 HOWELL TERRACE</b>					
3. NAME OF DECEASED (Type or print) <b>ROSIE</b>						4. DATE OF DEATH <b>HUBBARD NOV. 22 1966</b>					
5. SEX <b>F</b>						6. COLOR OR RACE <b>C</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>10-11-1900</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>					
13. FATHER'S NAME <b>William Robinson</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>						16. SOCIAL SECURITY NO <b>213-14-2342</b>					
17. INFORMANT <b>Robert Hubbard</b>						Address <b>418 Howell Terrace</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <b>Towson, Md.</b> DATE SIGNED <b>11-22-66</b> 22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <b>Burial 11-25-66</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery Anne Arundel Co. Md.</b> 22d. LOCATION (City, town, or country) (State) <b>NOV 25 1966</b> 24a. REC'D BY REGISTRAR <b>Charles Judge</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15285

CERTIFICATE OF DEATH

15284

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Lutherville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY in 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1507 Bedworth Rd.</b>		d. STREET ADDRESS <b>5628 Loch Raven Blvd</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna C.</b> Middle <b>Hughes</b> Last <b></b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1897</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR (Months) <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Pohlman</b>		14. MOTHER'S MAIDEN NAME <b>Crescentia Geiger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216 36 6398</b>	
17. INFORMANT <b>Mrs. Leonard W. Mayor, Lutherville, Md.</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown Thrombosis</b> DUE TO <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO <b></b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 <b>Nov 15</b> , to <b>Nov 15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov 15</b> , 19 <b>66</b> , and that death occurred at <b>5:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>E.P. Coffey</b>		22b. DATE SIGNED <b>11/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>E.P. Coffey</b>		22d. ADDRESS <b>3100 St. Paul St. Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Buried</b>	23b. DATE THEREOF <b>Nov. 17, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Balto., Md.</b>
24. FUNERAL DIRECTOR <b>Will. Cook-Brooks Towson, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>NOV 17 1966</b>	

1000

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

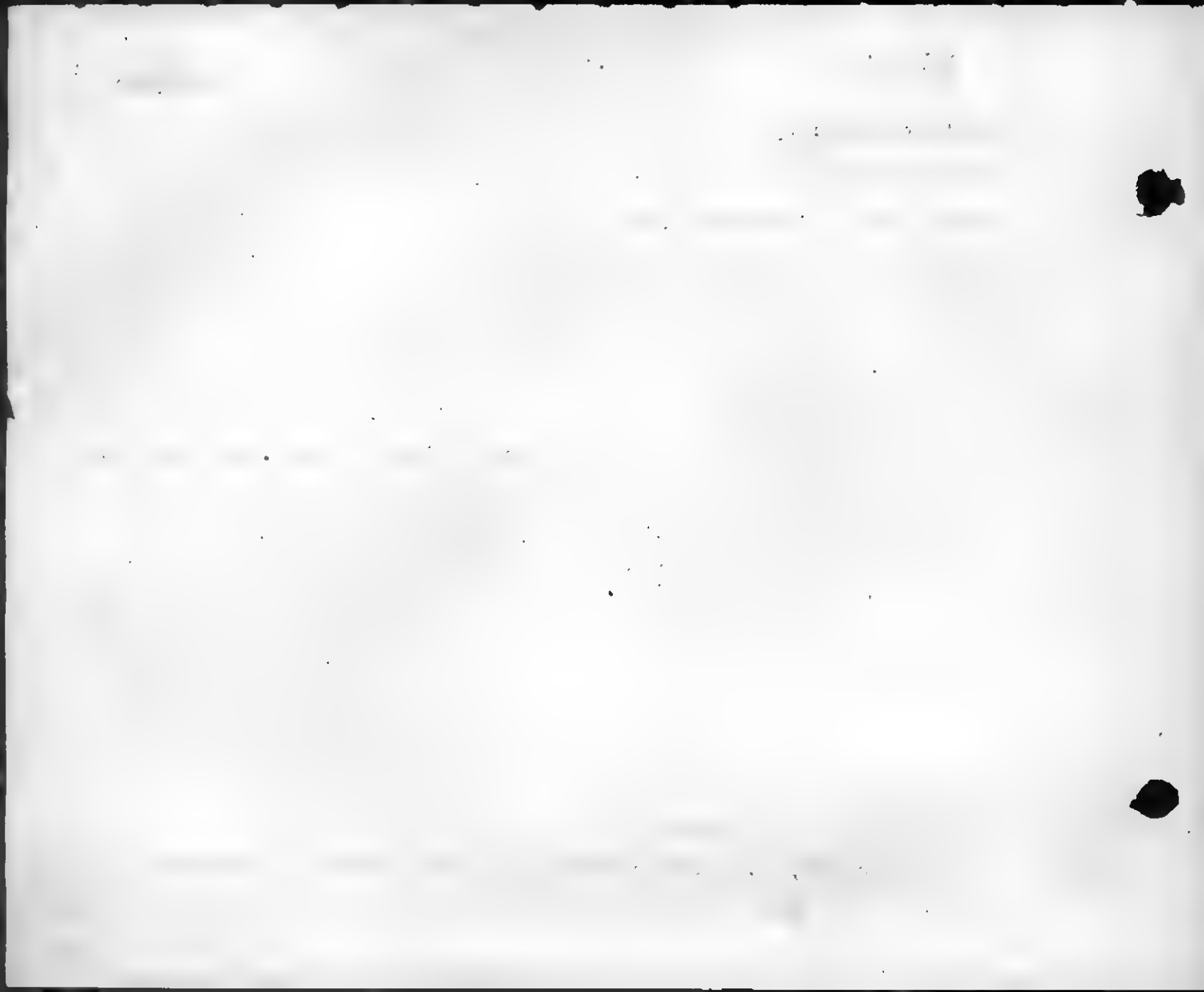
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15286

15285

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Baltimore City</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>			
c. LENGTH OF STAY IN 1b <b>1 yr.</b>				d. STREET ADDRESS <b>Victoria Hotel 704 B&amp;H. St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Francis William Hughes</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1966</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-12-99</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Hughes, Frank</b>			
14. MOTHER'S MAIDEN NAME <b>Washington, Emma</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-14-0552</b>				17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> 102-1 DUE TO (b) <b>Pulmonary Tuberculosis For Obvial</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Cachexia</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 7 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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768

(M)

15287

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15286

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>10-20-66-11-7-66</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Balto. Medical Center</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>4422 Underwood Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Edwin</b> First <b>Graves</b> Middle <b>Hundley</b> Last		4. DATE OF DEATH <b>11</b> Month <b>7</b> Day <b>19</b> Year <b>66</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-20-02</b>		9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Exec. Insurance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Huntington, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas Edwin Hundley</b>				14. MOTHER'S MAIDEN NAME <b>Lauri Graves</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWII</b>				16. SOCIAL SECURITY NO. <b>Link</b>				17. INFORMANT <b>MRS. EDNA SMITH HUNDLEY (SAME)</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO (b) <b>Brain Metastasis</b> DUE TO (c) <b>Bronchogenic Carcinoma</b> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>10-20-1966</b> to <b>11-7-1966</b> , that (I) (we) last saw the deceased alive on <b>11-7-1966</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Ram K. Chhillar</b> M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>												22b. DATE SIGNED <b>11-7-66</b>							
22c. PHYSICIAN'S NAME (Type) <b>RAM K. CHILLAR</b>												22d. ADDRESS <b>Greater Balto. Med. Center, Baltimore</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/10/1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity Churchyard</b>				23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>							
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>												25a. REC'D BY REGISTRAR <b>Charles Judge</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

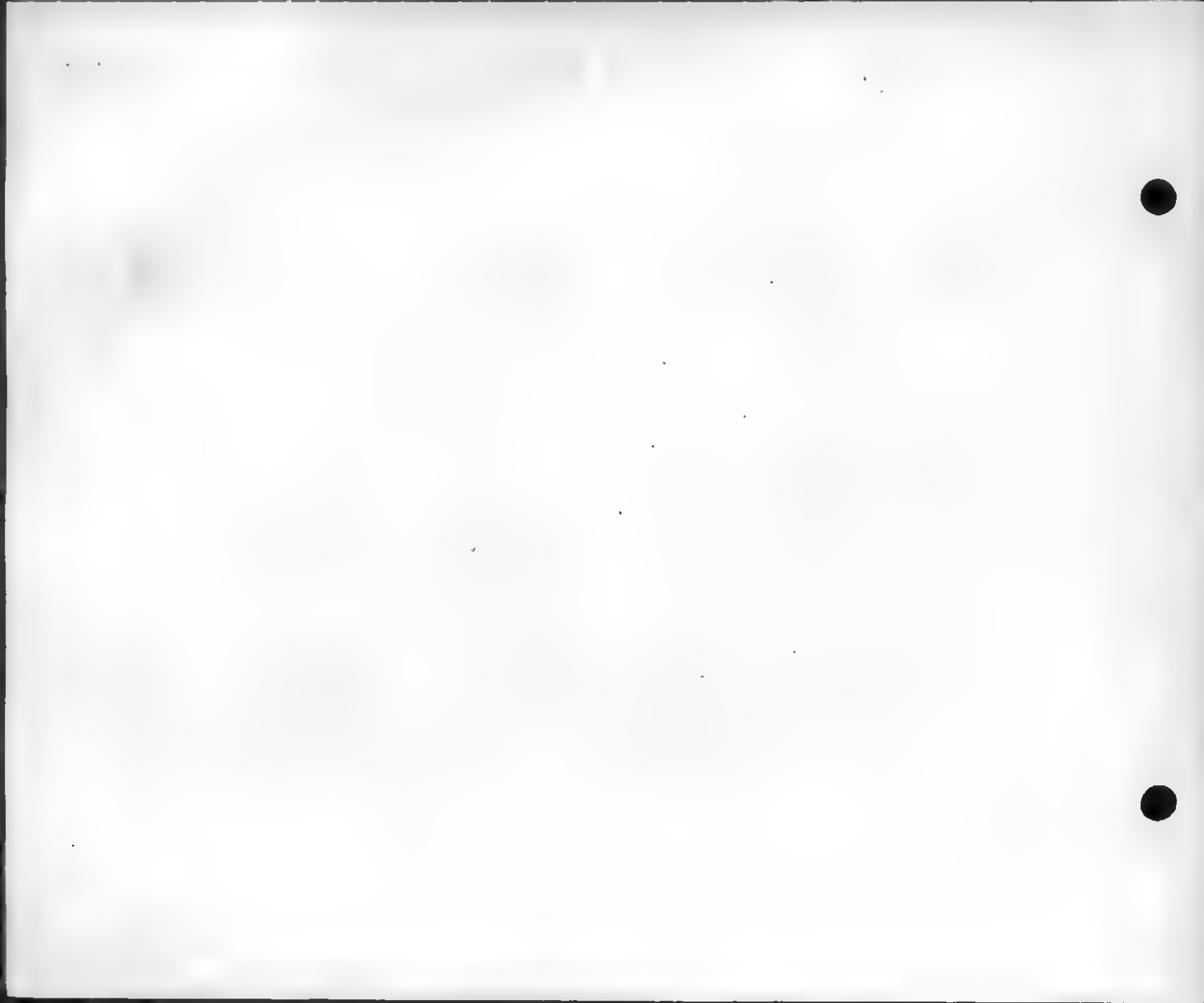
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15288

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15287

1 PLACE OF DEATH a COUNTY <u>BALTO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if instit on Residence before adm ssion) a STATE <u>MD.</u> b COUNTY <u>BALTO.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c LENGTH OF STAY IN tb	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>308 LORRAINE AVE</u>		d STREET ADDRESS <u>308 LORRAINE AVE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>EMIL R. ILLIAN</u>		4 DATE OF DEATH Month Day Year <u>NOV. 11 1966</u>	
5 SEX <u>M</u>	6 CO. OR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/25/1898</u>
9 AGE (In years last birthday) yrs <u>67</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAIL ROAD</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Canton R.R. Tunnison</u>		11 BIRTHPLACE (State or foreign country) <u>MD.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>FREDERICK ILLIAN</u>	
14 MOTHER'S MAIDEN NAME <u>UNK</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W. I</u>	
16 SOCIAL SECURITY NO. <u>Redacted</u>		17 INFORMANT Address <u>WIFE ABOVE</u>	
18 CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Failure</u> 5212 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Lung Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour <u>am</u> <u>pm</u> <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C. Patterson</u> EXAMINER'S NAME (Type) <u>THEO C. PATTERSON</u>		22. DATE SIGNED <u>11/11</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>11/15/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>BALTO. NATL.</u>		23d LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>	
24 FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>		25a ADDRESS <u>300 MACE</u>	
25b. REC'D BY REGISTRAR <u>NOV 17 1966</u>		25c. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

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VR A15ME  
3500 4-64

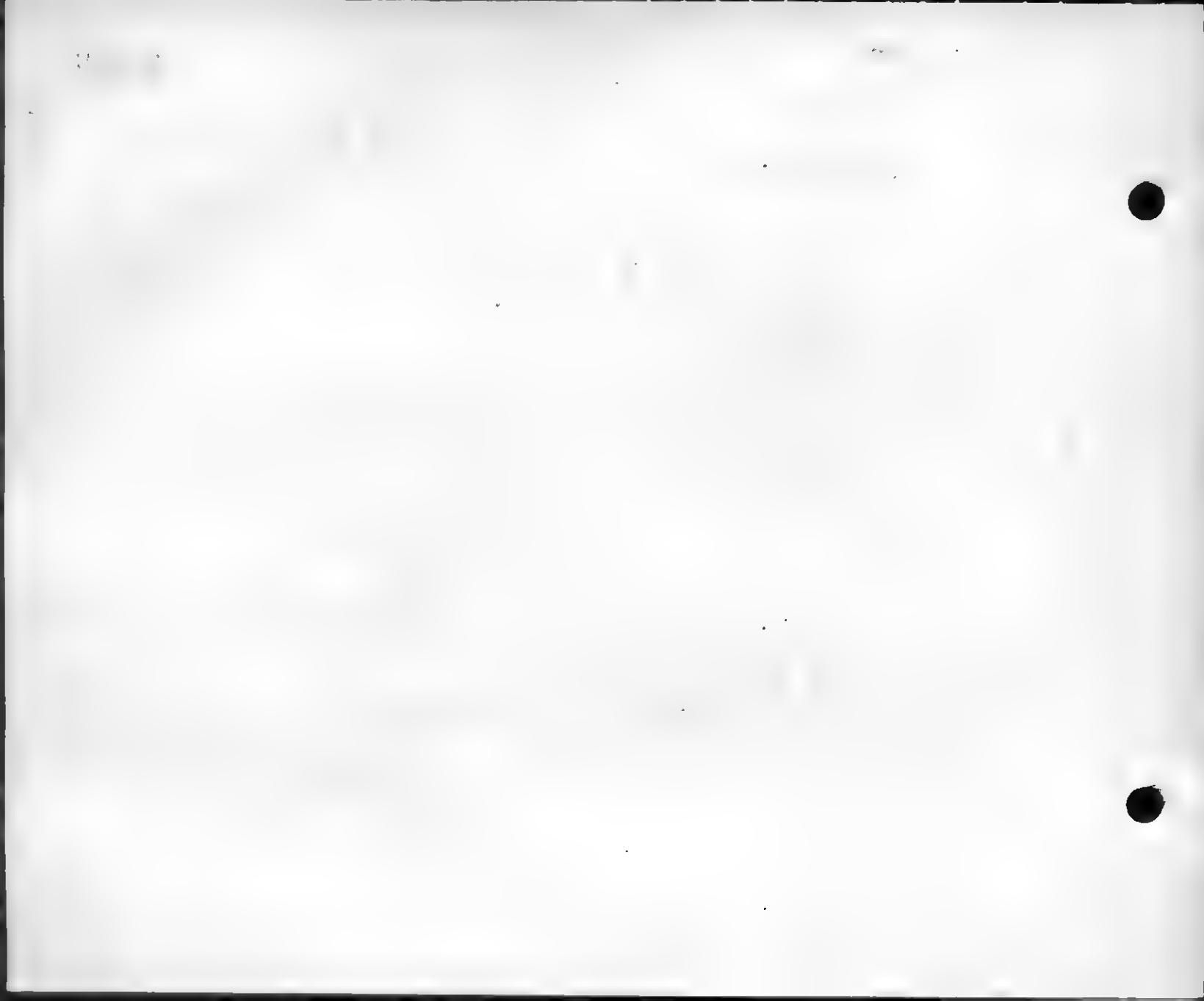
<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>FOR STATE HEALTH DEPT.</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>15289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>15288</p> </div> </div>										
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN 1b <b>32 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7026 BELCLARE ROAD</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD. 21222</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> d. STREET ADDRESS <b>7026 BELCLARE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HURLUF ALBERT JAGD</b>			4. DATE OF DEATH <b>11/8/1966</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
8. DATE OF BIRTH <b>FEB. 2, 1907</b>			9. AGE (In years last birthday) <b>59</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFG.</b>		11. BIRTHPLACE (State or foreign country) <b>DENMARK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>ALB ERT JAGD</b>		14. MOTHER'S MAIDEN NAME <b>ALBERTA ***</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-7915</b>	
17. INFORMANT <b>GWENDOLYN W. JAGD - AS IN # 2 - WIFE</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>43X</b> (c) <b>Alcoholism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. CO. MD.</b>	
24. FUNERAL DIRECTOR <b>W. BROOKS BRADLEY, DUNDALK, MD.</b>			25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. EXAMINER'S NAME (Type) <b>M. B. DAVIS-6800 MORNINGTON ROAD, BALTO. CO. MD.</b>		25d. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>15290</p> <p>1</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15289</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u>				c. LENGTH OF STAY IN 1b <u>10 mo.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foreign Nursing Home</u>				d. STREET ADDRESS <u>2358 Wilkens Ave. Reisterstown Valley Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Timothy North Soffords Sr</u>				4. DATE OF DEATH Month Day Year <u>November 13 1966</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1903</u>		9. AGE (In years last birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stat. engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial</u>				11. BIRTHPLACE (County & State, or foreign country) <u>S. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>TAYLOR P. Soffords</u>				14. MOTHER'S MAIDEN NAME <u>MARY IDA Hudson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>248-12-0264</u>		17. INFORMANT <u>Thomas P. Soffords</u>		Address <u>Box 391 MILLERSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>unknown</u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>January 13, 1966</u> to <u>November 13, 1966</u> , that (1) (we) last saw the deceased alive on <u>November 13, 1966</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>David T. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED <u>11-13-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>David T. Miller</u>								22d. ADDRESS <u>Lisbon Rd - Owings M. Hs Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>				23d. LOCATION (City, town or county) (State) <u>Howard City Md</u>			
24. FUNERAL DIRECTOR <u>Geo. H. Schwab Funeral Home</u> ADDRESS <u>Francis H. Miller 2101 Medical Ave.</u>								25a. REC'D BY REGISTRAR DATE <u>NOV 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15291

CERTIFICATE OF DEATH

15290

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c LENGTH OF STAY IN lb <u>26 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>LAWRENCE</u> Last <u>Jenkins</u>				4 DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1966</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-7-10</u>	9 AGE (In years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>8</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Security Supervisor</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13 FATHER'S NAME <u>John Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give War or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>unknown</u>		17 INFORMANT <u>HOSPITAL Records</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>central hemorrhage + Edema</u> DUE TO (b) <u>Postoperative Ruptured craniotomy. Clipping of cerebral artery</u> DUE TO (c) <u>Cerebral aneurysm Ant. cerebral A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u>10-13-66</u> <u>11-7-66</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>13 Oct</u> , 19 <u>66</u> , to <u>7 Nov</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8 Nov</u> , 19 <u>66</u> , and that death occurred at <u>SURAM</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Alberto S. Barretto</u>				22b DATE SIGNED <u>11-8-66</u>		22c PHYSICIAN'S NAME (Type) <u>ALBERTO S. BARRETTO, M.D.</u>	
22d ADDRESS <u>Balto County Gen. Hosp. Randallstown, Md</u>				22e MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22f ATTENDING PHYS <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Nov. 11, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Randallstown, Md.</u>	
24 FUNERAL DIRECTOR <u>Newell Funeral Home, Baltimore - 8-Md</u>				25 REC'D BY REGISTRAR <u>NOV 14 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (See pages 1 and 2 with the State Department of Health as it's designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.)

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15291

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>md.</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c LENGTH OF STAY IN 1b <u>Baldwin</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 210 Carroll Manor Road</u>		d STREET ADDRESS <u>Box 210 Carroll Manor Road</u>	
3 NAME OF DECEASED (Type or print) <u>Lulu</u> First <u>K.</u> Middle <u>Jimmy</u> Last		4 DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>19 66</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-17-1885</u>
9 AGE (In years last birthday) <u>81</u> yrs		10 F UNDER 1 YEAR Months <u>15</u> Days <u>19</u> Hours <u>66</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USci</u>	
13 FATHER'S NAME <u>William Knieriem</u>		14 MOTHER'S MARRIED NAME <u>Mary</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>John J. Jimmyer</u>		Address <u>Schuster Road</u> <u>Garrettsville, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Hypertensive Cardia</u> most (c) <u>Renal Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> o'm p'm		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <u>11/16/66</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>11-17-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15293

CERTIFICATE OF DEATH

15292

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>16 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>335 MASON COURT</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLAUDE WADE JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 10 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16, 1892</b>
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH LONG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218 05 06 44</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLI AND INFARCTION</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ATRIAL FIBRILLATION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE</b>			INTERVAL BETWEEN ONSET OF DEATH <b>DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he/she) attended the deceased from <b>10/25/66</b> , 19__ to <b>11/10/66</b> , 19__, that (s/he) last saw the deceased alive on <b>11/10/66</b> , 19__, and that death occurred at <b>1:00A</b> M, from causes and on the date stated above			
22a. SIGNATURE <i>Sheldon E. Kaimutz</i>		22b. DATE SIGNED <b>11/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KAIMUTZ, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>George A. Kilar</i> <b>1548N</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

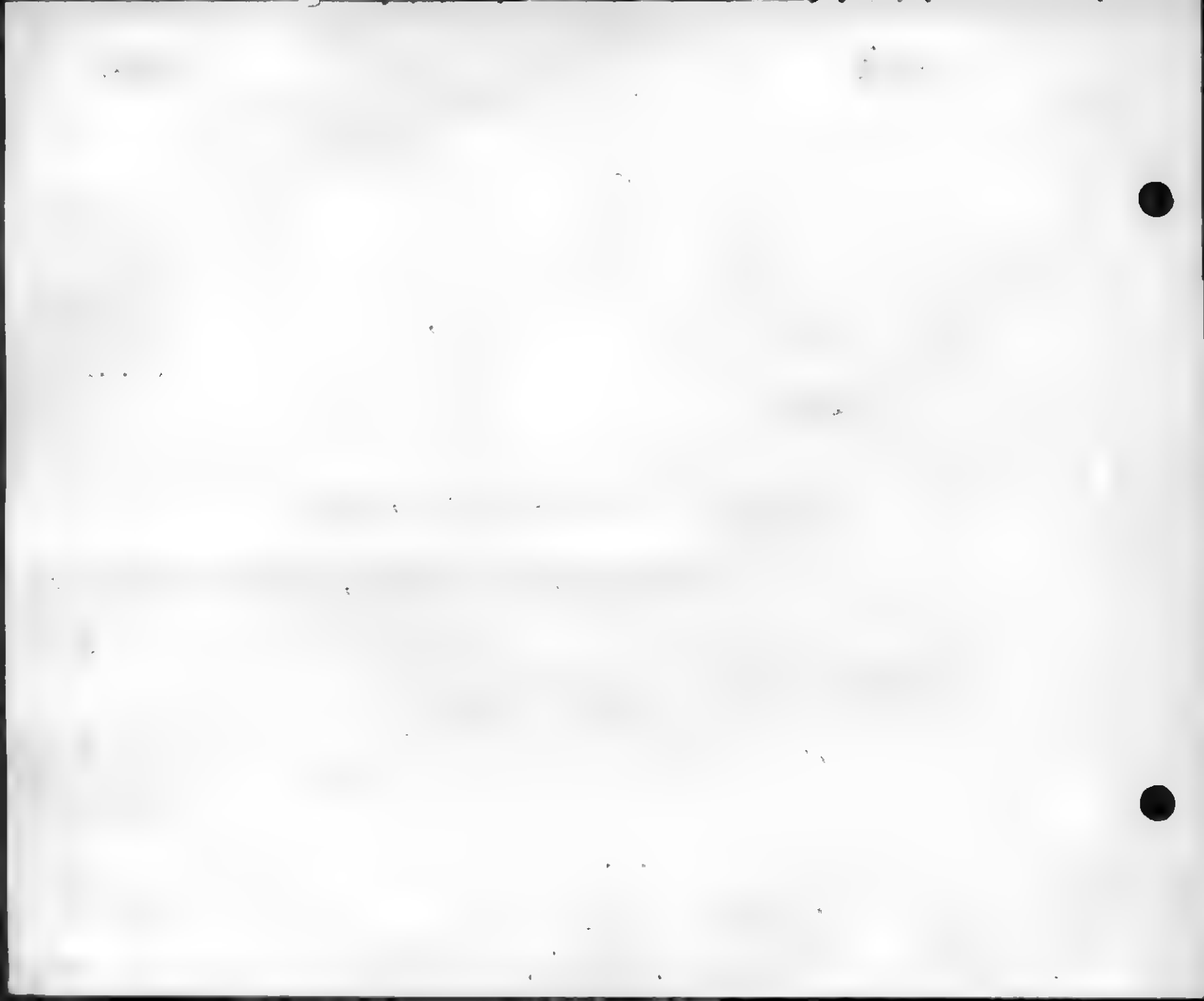
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15294

CERTIFICATE OF DEATH

15293

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>12 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>727 NORTH AVONDALE ROAD</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JEROME NATHANIEL JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 16 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 2, 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>EDWARD JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>EMMA PRIDGETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>216 05 34 06</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RIGHT PULMONARY INFARCTION, RECENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE, AORTIC INSUFFICIENCY YEARS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>17</b> (this hospital) attended the deceased from <b>NOV 4</b> , 19 <b>66</b> , to <b>NOV 16</b> , 19 <b>66</b> , that <b>17</b> (we) last saw the deceased alive on <b>NOV 16</b> , 19 <b>66</b> , and that death occurred at <b>4:00 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson Neilson</i>		22b. DATE SIGNED <b>11/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILSON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Marshall P. Hayes</i>		25a. REC'D BY REGISTRAR <b>NOV 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME <b>CHARLES JUDGE</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 12 Film 3383 12/9/66 mh

15295

CERTIFICATE OF DEATH

15294

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Towson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>031</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		d. STREET ADDRESS <u>6728 Queens Ferry Road</u>	
3. NAME OF DECEASED (Type or print) <u>Jeronimas (Jaronimas) Joksas (Joksus)</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1888</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Raymond J. Zerkowicz 2011-29-69 2011-29-69</u>		Address <u>2011-29-69 2011-29-69</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u> DUE TO <u>A. S. C. V. D.</u> (b) <u>Generalized arteriosclerosis</u> DUE TO <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11.12</u> to <u>11.14</u> , 19 <u>66</u> that (I) (we) lost the deceased alive on <u>11.15</u> 19 <u>66</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley Ankudis</u>		22b. DATE SIGNED <u>11.15.66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDIS</u>		22d. ADDRESS <u>1601 Maiden Choice La. 41229</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 17 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc 1600 Hollis Balt. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

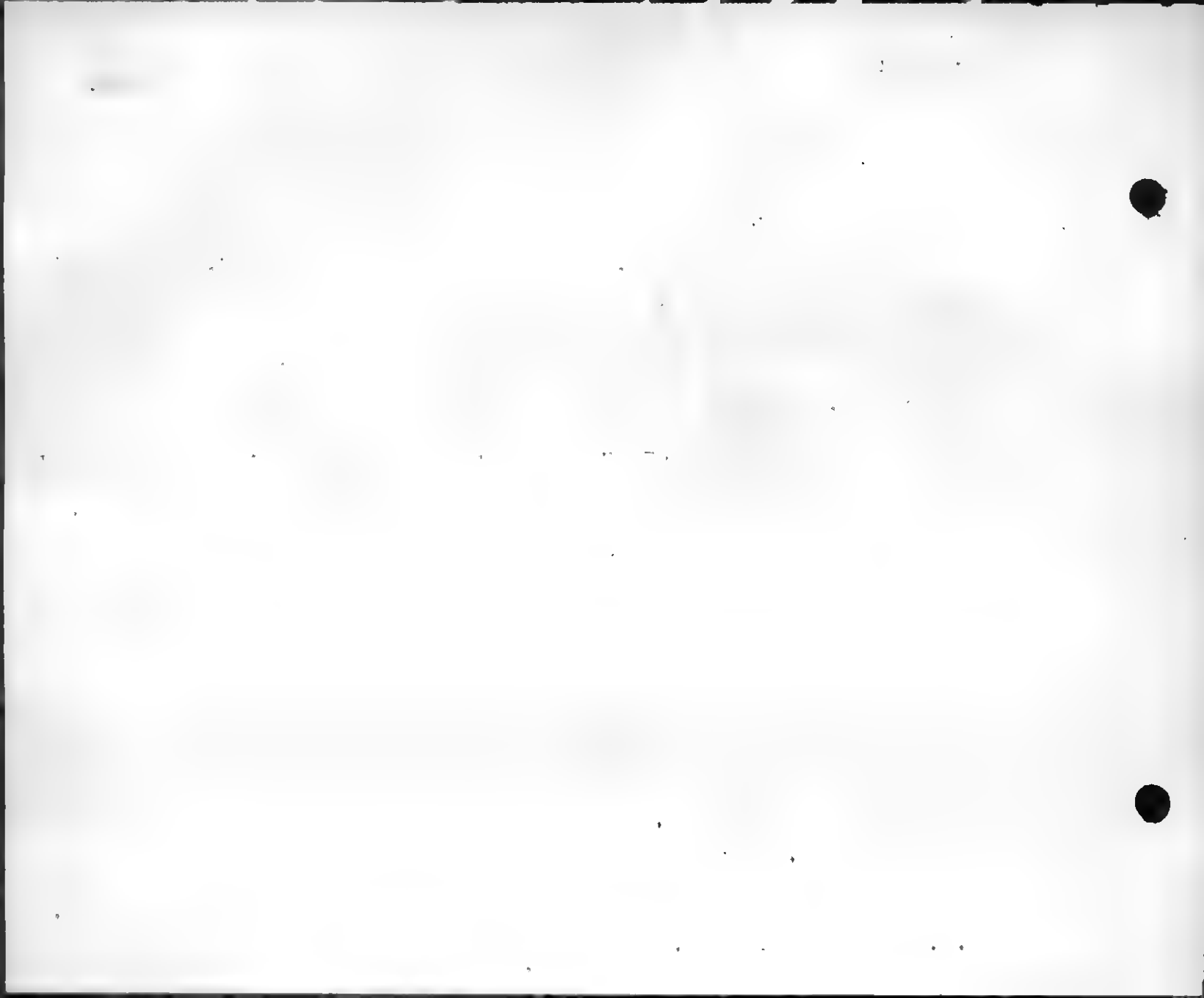
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15296

CERTIFICATE OF DEATH

15295

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>501 Murdock Road</b>		d. STREET ADDRESS <b>501 Murdock Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary R. Jones</b>		4. DATE OF DEATH Month Day Year <b>Nov. 8 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>11/23/1876</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest W. Schultz</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Phillips</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-5016</b>	
17. INFORMANT <b>Mrs. Clara M. Graham</b>		Address <b>530 Murdock Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 4, 1964</b> , to <b>Nov 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>11/9/66</b> , and that death occurred at <b>9A</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence E. Post</b>		22b. DATE SIGNED <b>11/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lawrence E. Post</b>		22d. ADDRESS <b>6805 York Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	23b. DATE THEREOF <b>11/11/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Mausoleum</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>4905 York Road Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT.

15297

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 551m 6382 11/16/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15296

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY					
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)			c LENGTH OF STAY N 1b <b>6 Mos.</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d STREET ADDRESS <b>1429 Limit Ave.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>M.</b> Last <b>Jordan</b>				4 DATE OF DEATH Month <b>11/</b> Day <b>6</b> Year <b>1966</b>					
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>1891</b> <b>5/18/1881/</b>			
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Parker H. Jordan</b>				14. MOTHER'S MAIDEN NAME <b>Annie M. Robinson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17 INFORMANT <b>Clara H. Miller, (Sister)</b> Address <b>1429 Limit Av.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Coarctation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type)			M.D. <b>Charles F. O'Donnell, M.D.</b>			22. DATE SIGNED <b>11/6/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>			1217 St. <b>Adams St.</b> <b>Baltimore 2, Maryland</b>			25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the health certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

15298

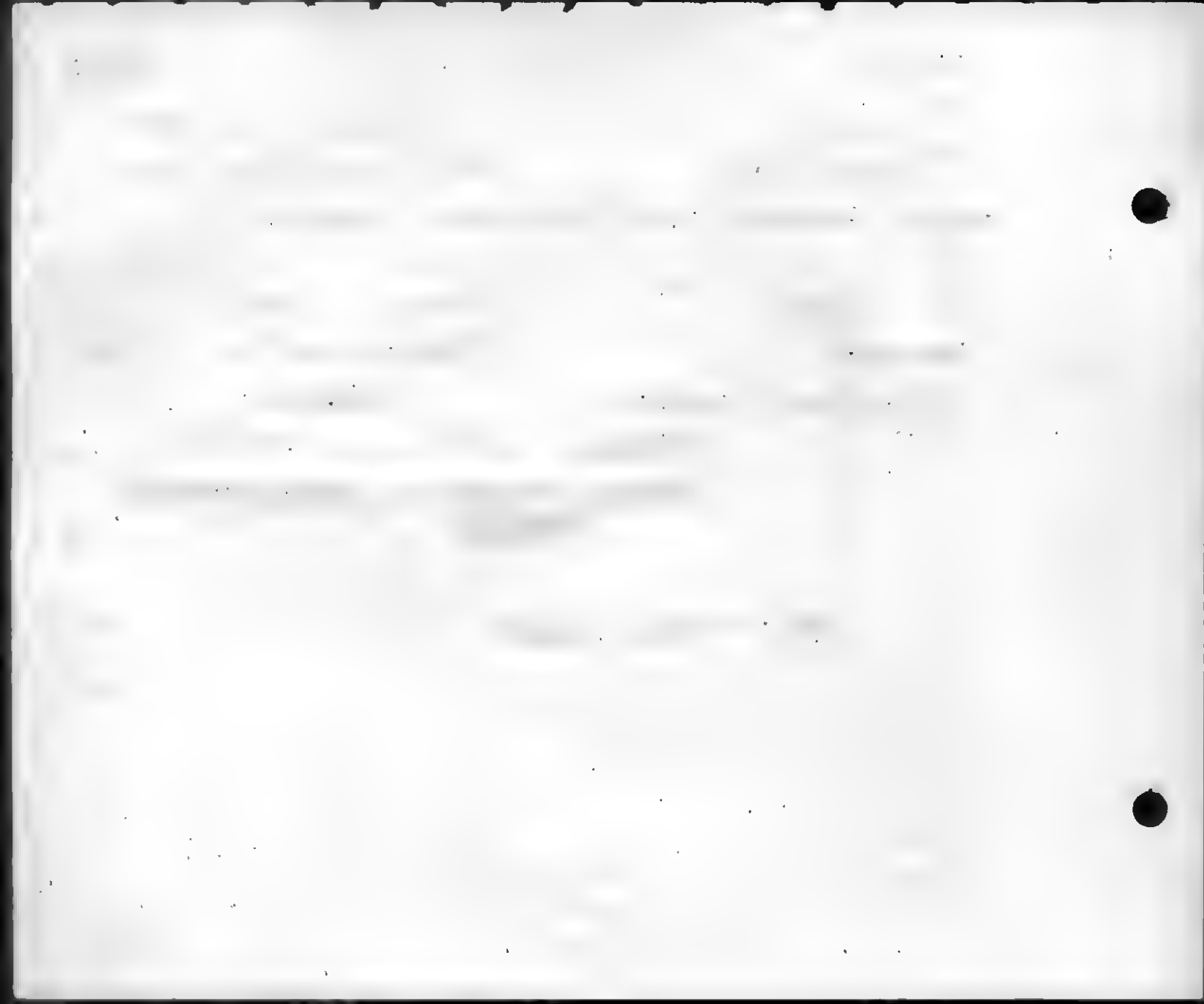
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15297

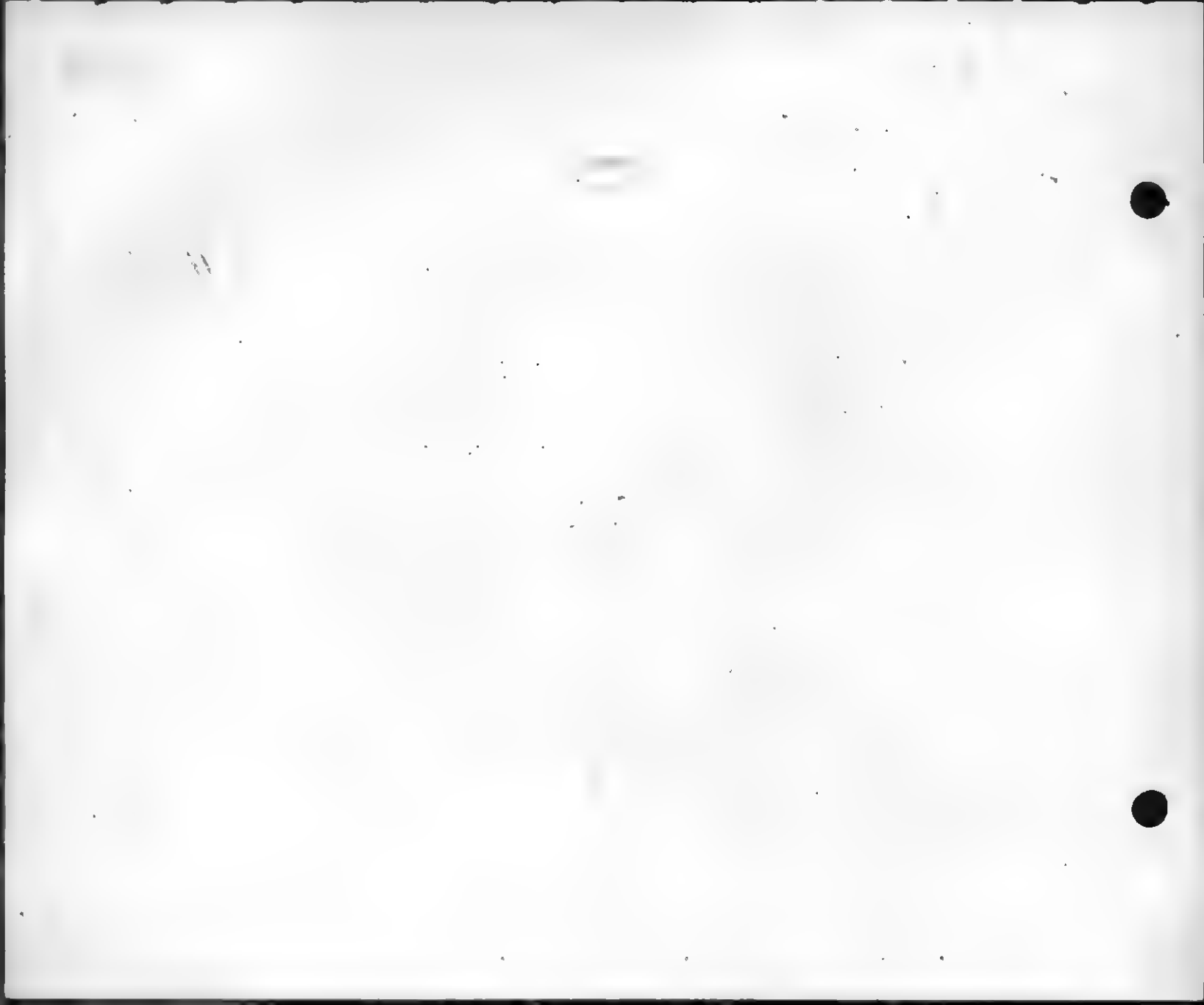
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson - Md.</u> c. LENGTH OF STAY IN 1b <u>21/24</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BAL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Md.</u> d. STREET ADDRESS <u>3608 Echodake</u>			
3. NAME OF DECEASED (Type or print) <u>VICTORIA</u> First <u>Anne</u> Middle <u>KALENDE</u> Last <u>K</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-14</u>	9. AGE (in years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore - Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Valentine Glodek</u>			14. MOTHER'S MAIDEN NAME <u>Marcella Jakobowski</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216919586</u>		17. INFORMANT <u>Admission Sheet Kalende - same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>10 YRS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>HYPOTHYROIDISM</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>66</u> , to <u>11/8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> , 19 <u>66</u> , and that death occurred at <u>8:20</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>James P. G. Hyman</u>		22b. DATE SIGNED <u>11/8/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Greater Baltimore Med. Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery Baltimore, Md.</u>			
23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>					
25a. RECEIVED BY REGISTRAR <u>NOV 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15299		Items #1, 21 & 22b Film #837-3/22/66						15298			
1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St Joseph</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson, Md</u> d. STREET ADDRESS <u>25 Gunpowder Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Joshua Alexander</u>		First <u>Joshua</u> Middle <u>Alexander</u> Last <u>KANE</u>		4. DATE OF DEATH <u>11-28-1966</u>		Month <u>11</u> Day <u>28</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-03</u>		9. AGE (in years last birthday) <u>63</u> yrs. Months <u>0</u> Days <u>0</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>V.P. Mercantile</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Trust-Banking</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Balto Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Alexander Kane</u>				14. MOTHER'S MAIDEN NAME <u>Isabel Mewshaw</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-03-7622</u>		17. INFORMANT <u>Wife</u>		Address <u>25 Gunpowder Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> (c) <u>ASCVD</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>6400</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>66</u> , to <u>Nov. 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-26-1966</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>D.A. Ounsler</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/28/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>D.A. Ounsler, MD</u>				22d. ADDRESS <u>1118 St. Paul St.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>12-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>				4905 York Rd. 12				25a. REC'D BY REGISTRAR <u>NOV 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	

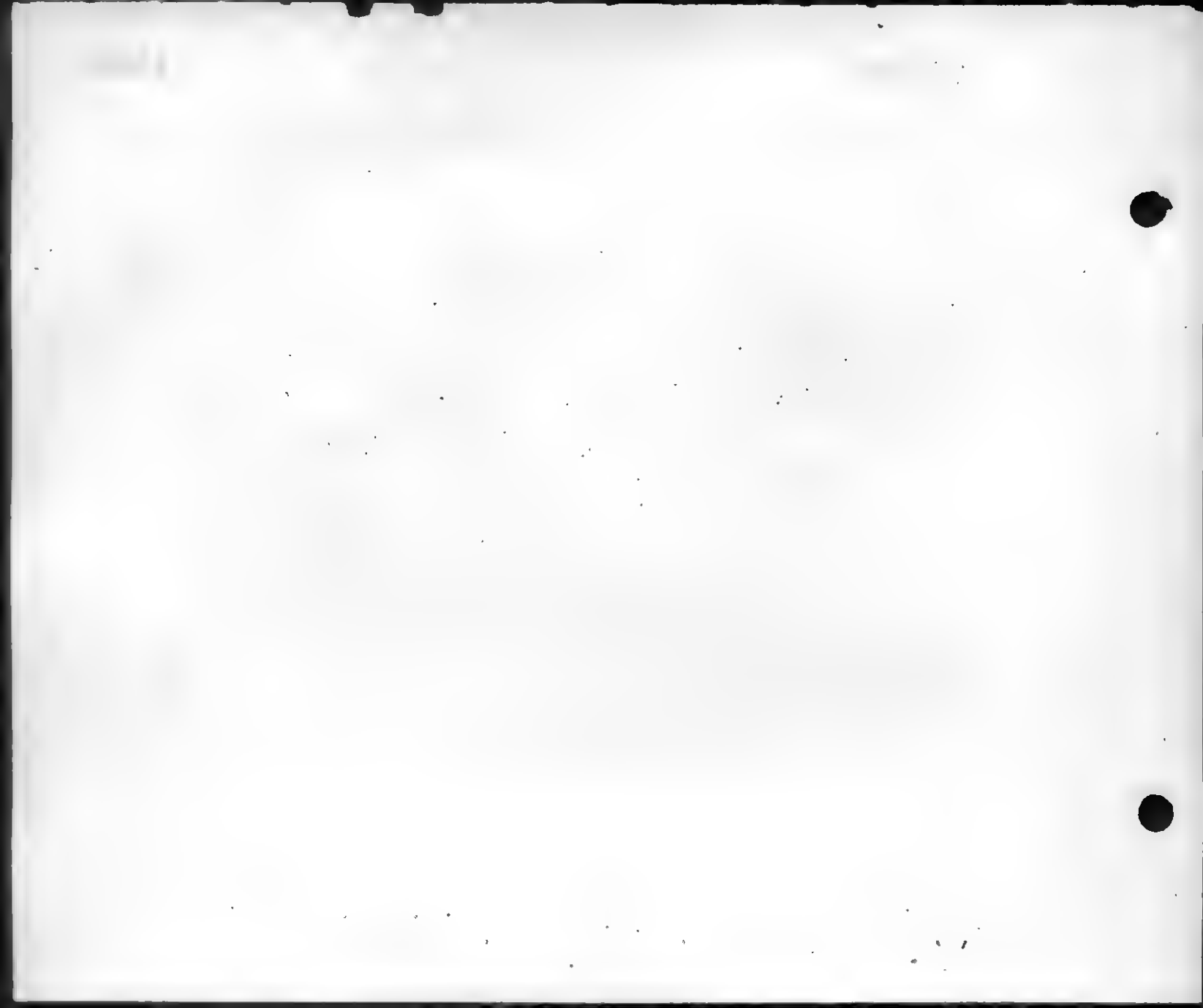


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15300					15299				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>BALTIMORE</u>					b. STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO MED CENTER</u>					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <u>MRS RUTH</u> First <u>EVERLYN</u> Middle <u>KANSLER</u> Last					4. DATE OF DEATH <u>NOV</u> <u>23</u> <u>19</u> <u>66</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-94</u>		9. AGE (in years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. MGR NURSING HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>EDWARD MARTIN GLORWIS</u>					14. MOTHER'S MAIDEN NAME <u>FLORENCE BAIRD</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 282104</u>		17. INFORMANT <u>(SON) BRENT KANSLER (same)</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Respi. Failure</u> DUE TO (b) <u>Carcinoma of vulva with</u> underlying cause last. (c) <u>metastases.</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (s) (this hospital) attended the deceased from <u>Oct 17, 1966</u> to <u>Nov 23, 1966</u> that (s) (we) last saw the deceased alive on <u>Nov 23, 1966</u> , and that death occurred at <u>4:30 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Denis Chan</u>				ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>NOV 23 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>				22d. ADDRESS <u>G B M C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>11/25/1966</u>		<u>Dulaney Valley Mem. Grds. Timonium, Md.</u>					
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>NOV 23 1966</u>					

MEDICAL CERTIFICATION





Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15301

## CERTIFICATE OF DEATH

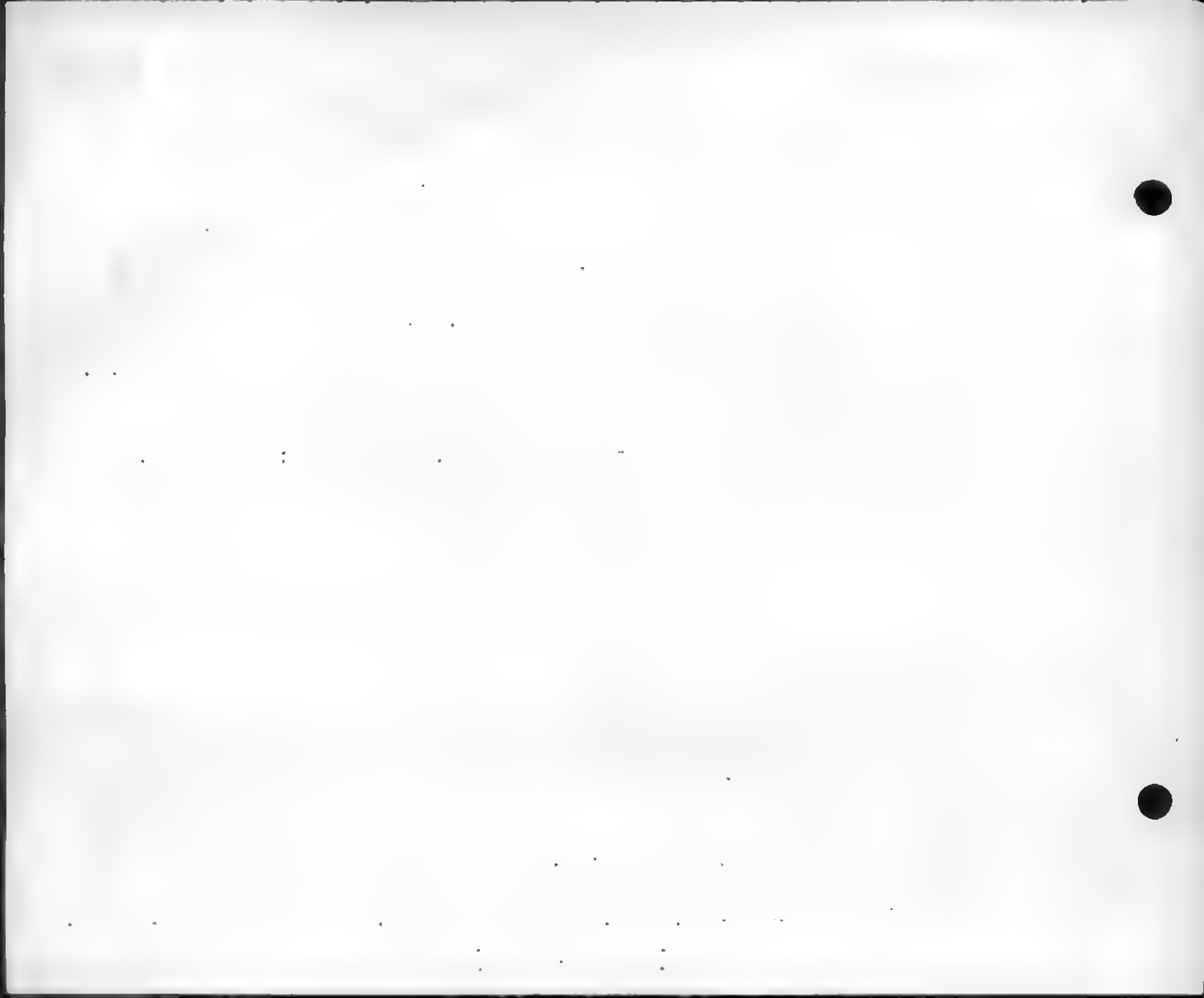
+Autopsy

15300

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admittance) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>8128 Pleasant Plains Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Kraig</b> Middle <b>A.</b> Last <b>Karwacki</b>		4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1965</b>
9. AGE (In years last birthday) yrs <b>11</b> Months <b>22</b> Days <b>11</b> Hours <b>22</b> Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul F. Karwacki</b>		14. MOTHER'S MAIDEN NAME <b>LaVerne M. Brenner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Paul F. Karwacki :</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebral edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>acute purulent meningitis</b> DUE TO (c) <b>Hemophilus Parainfluenzal</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <b>11-21</b> , 19 <b>66</b> , to <b>11-21</b> , 19 <b>66</b> that (A) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>66</b> , and that death occurred at <b>8:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i>		22b. DATE SIGNED <b>11/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-25-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>6515 Boston St. Balto. 24 Md</b>
24. FUNERAL DIRECTOR <i>Charles S. Jailer</i>		25a. REC'D BY REGISTRAR <b>NOV 25 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Jailer</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15302

CERTIFICATE OF DEATH

15301

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>7 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>939 N. DALLAS STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM MC KENLEY KEENE</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 1 19 66</b>			
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>NEGRO</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>10/5/96</b>	
9 AGE (In years last birthday) <b>70</b> yrs.		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11 BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOHN KEENE</b>				14 MOTHER'S MAIDEN NAME <b>MARTHA MN: UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give year or dates of service) <b>WW I</b>		16 SOCIAL SECURITY NO. <b>213 07 22 70</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL EDEMA</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE MYELOMA, PROBABLE. BENIGN PROSTATIC HYPERTROPHY</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
						RECENT	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he/she) attended the deceased from <b>10/25/66</b> , 19 to <b>11/1/66</b> , 19, that (he/she) last saw the deceased alive on <b>11/1/66</b> , 19, and that death occurred at <b>11:50 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>11/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>				22d. ADDRESS <b>VAH FT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov 7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR ADDRESS <b>ROBERT E. WILLIAMS</b> <b>1701 N. Bond St. Baltimore, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15303

CERTIFICATE OF DEATH

15302

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Baltimore</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8506 Chestnut Oak Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>William P. Keller</u>		4. DATE OF DEATH <u>November 5, 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 7, 1897</u>
9 AGE (In years last birthday) <u>68</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Carrier</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Keller</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Keller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO <u>212-34-5723</u>		17 INFORMANT <u>Mrs. Alice V. Keller</u> Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>late Myocardial Infarction</u> DUE TO (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>16 min</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1962</u> to <u>Nov 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 4, 1966</u> , and that death occurred at <u>4:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard Kravel</u>		22b. DATE SIGNED <u>11/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Richard Kravel</u>		22d. ADDRESS <u>705 West A. St. Baltimore Md 21201</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Ind.</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>		25a REC'D BY REGISTRAR DATE <u>NOV 9 1966</u>	
25b REG STRAP'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 3-332 11/18/66 mh

15304

## CERTIFICATE OF DEATH

15303

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>C311</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2105 Thistlebloom St</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM C KELLEY</b> First Middle Last 4. DATE OF DEATH <b>11-12-1966</b> Month Day Year		5. SEX <b>M.</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>12-19-1879</b> 9. AGE (In years last birthday) <b>86</b> 10. US. A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unk.</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO 17. INFORMANT <b>Mrs. Conrad Gebel</b> <b>Hosp. Records</b> Address <b>3108 Grindon Ave. # 14</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarct.</b> 42A1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>11-8</b> , 19 <b>66</b> , to <b>11-12</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>11-12</b> , 19 <b>66</b> , and that death occurred at <b>1040 AM</b> from causes on and on the date stated above. 22a. SIGNATURE <b>Narciso W. Carmoiva</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>NARCISO W. CARMOIVA</b> 22d. ADDRESS <b>Spring Grove State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11-15-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE DATE <b>NOV 14 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15305

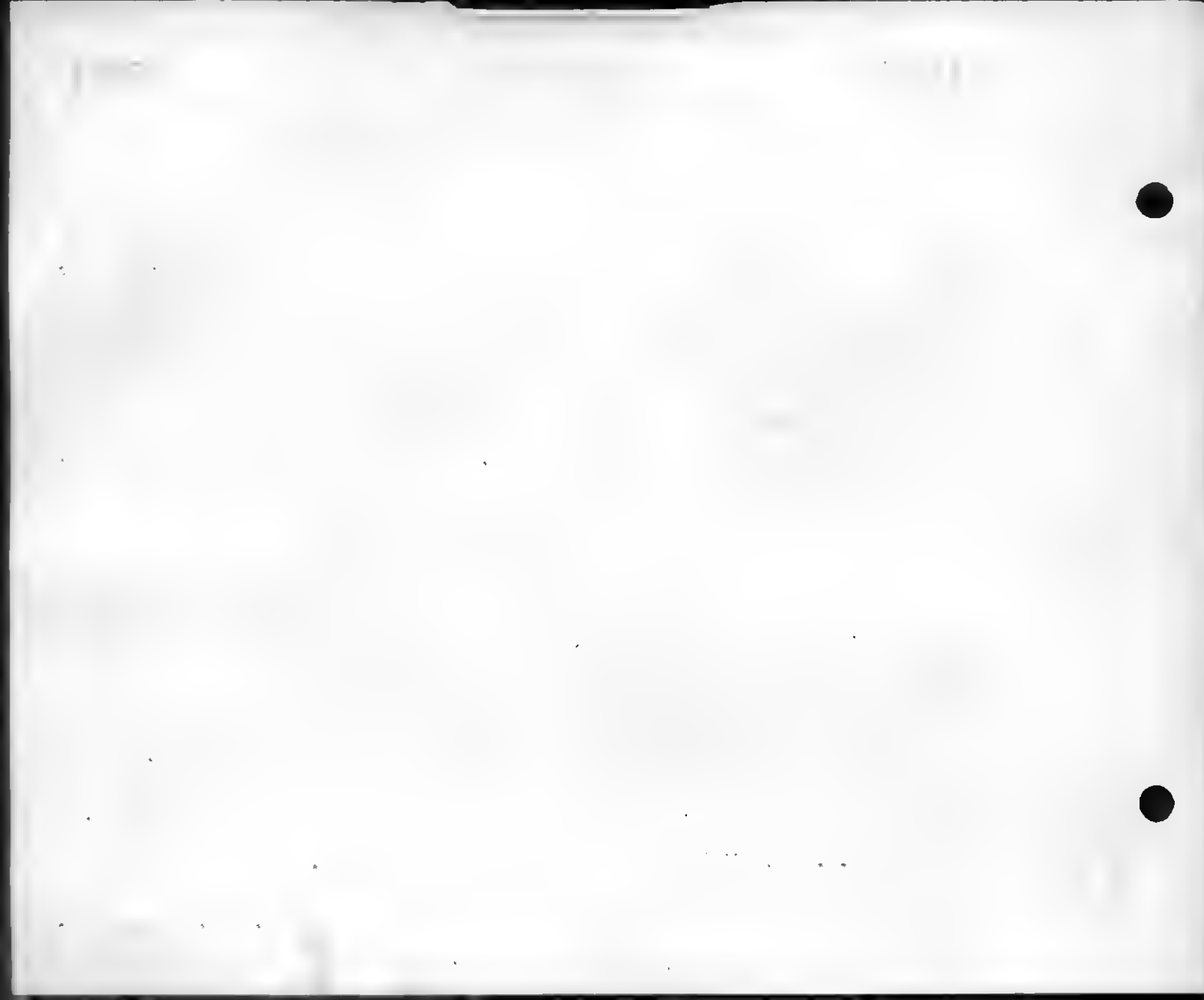
## CERTIFICATE OF DEATH

15304

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Hampstead</b>		c. LENGTH OF STAY IN 1b <b>12 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Grace Road</b>		d. STREET ADDRESS <b>Grace Road</b>	
3 NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>BEULAH</b> Last <b>KEMP</b>		4 DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 1, 1886</b>
9 AGE (In years last birthday) <b>80</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Benjamin Nash</b>	
14. MOTHER'S MAIDEN NAME <b>Rosa Ensor</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>220-34-6663</b>		17. INFORMANT Address <b>Mr. Archibald Kemp, Hampstead, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic C-V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Nov 20, 1966</b> to <b>Nov 13, 1966</b> , that (1) (we) last saw the deceased alive on <b>Nov 11, 1966</b> , and that death occurred at <b>11:55</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Maurice C. Porterfield</b> M.D.		22b. DATE SIGNED <b>11-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield</b>		22d. ADDRESS <b>Hampstead, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Co. Md.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Tipton-Eline Fun.Home, Hampstead, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

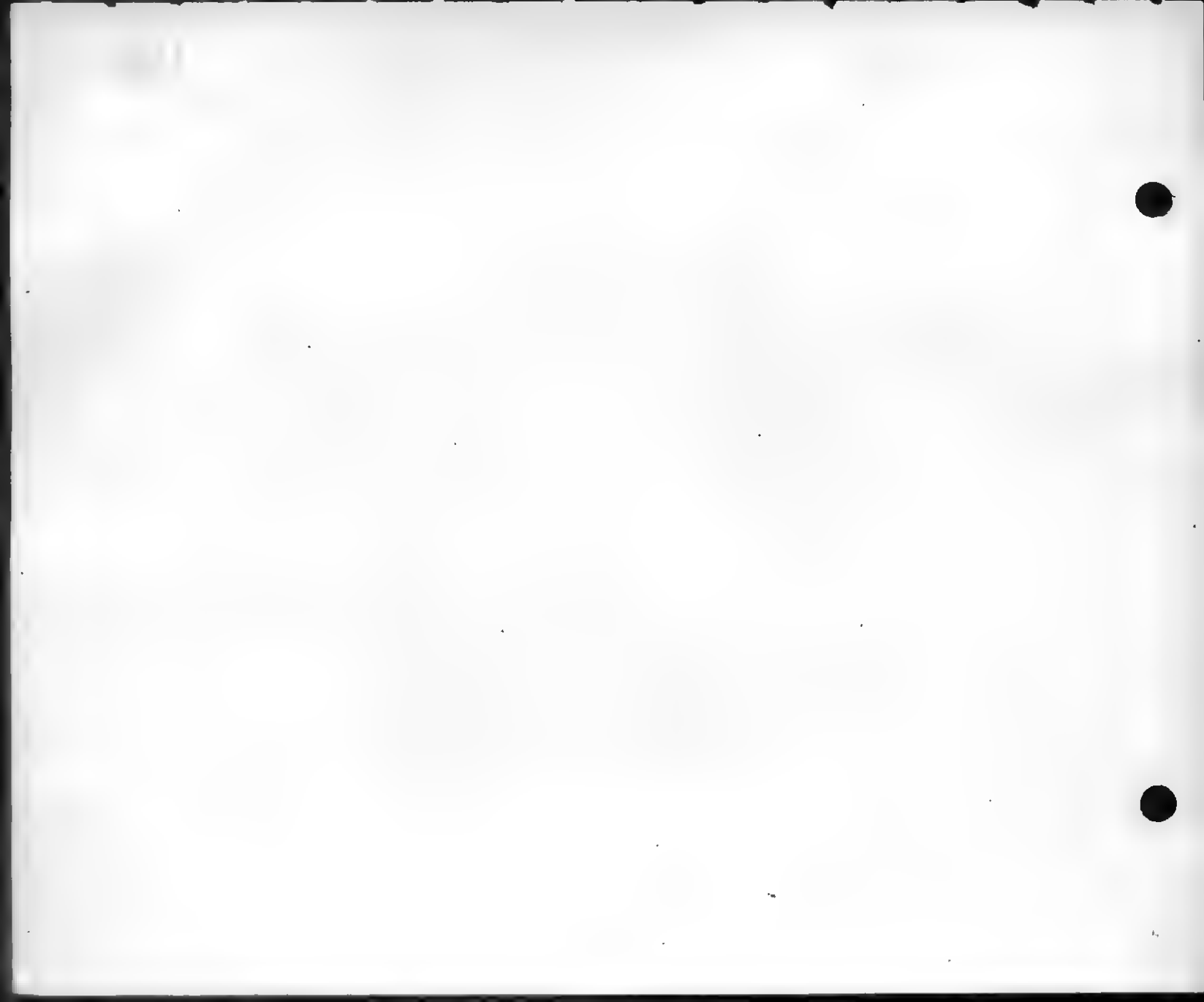
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

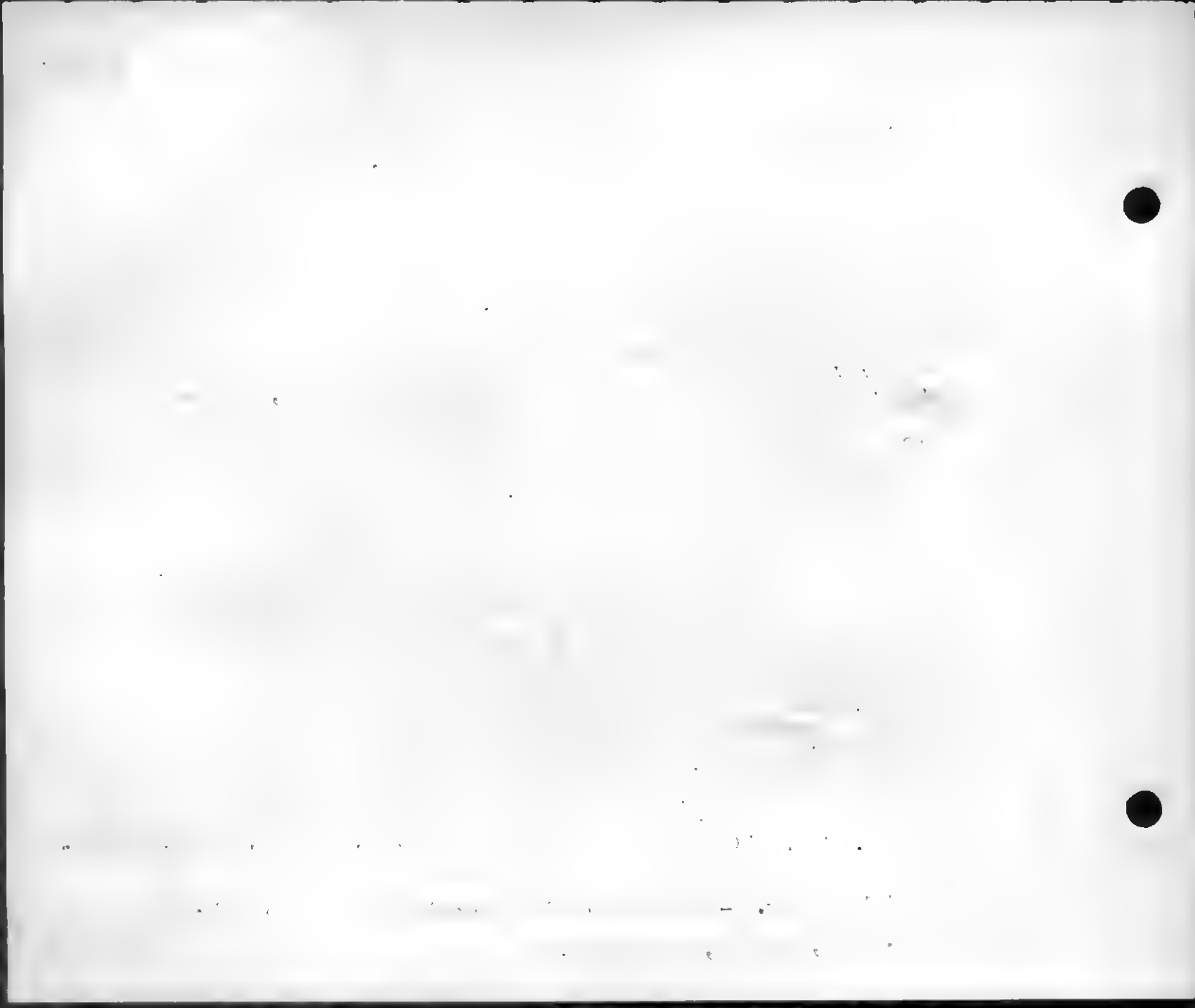
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15306											
Items 8, 9, 12 fill in 11/26/67 mh											
15305											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>11</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8015 YORK RD.</b>						d. STREET ADDRESS <b>136 CHERRY DELL RD</b>					
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>K.</b> Last <b>KEOGH</b>						4. DATE OF DEATH Month <b>NOV.</b> Day <b>24</b> Year <b>1966</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1899</b> <b>JULY 17, 1901</b>		9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STENOGRAPHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OIL</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Dublin, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM J. KEOGH</b>						14. MOTHER'S MAIDEN NAME <b>BRIDGET LYNCH</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>216-03-0026</b>		17. INFORMANT Address <b>ALVIN KEOGH-4728 DARTMOUTH RD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION-MYOCARDIAL INFARCTION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ATHEROSCLEROTIC CV DISEASE-SEVERE MYOCARDIAL DAMAGE</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 16, 1963</b> , to <b>NOV. 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>NOV. 6, 1966</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John F. Schaefer</b>						22b. DATE SIGNED <b>NOV. 25 1966</b>			22c. PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER MD</b>		
22d. ADDRESS <b>401 RANDOM RD.-BALTO. MD. 21229</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Harley Connaughton, Catonsville, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>NOV 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



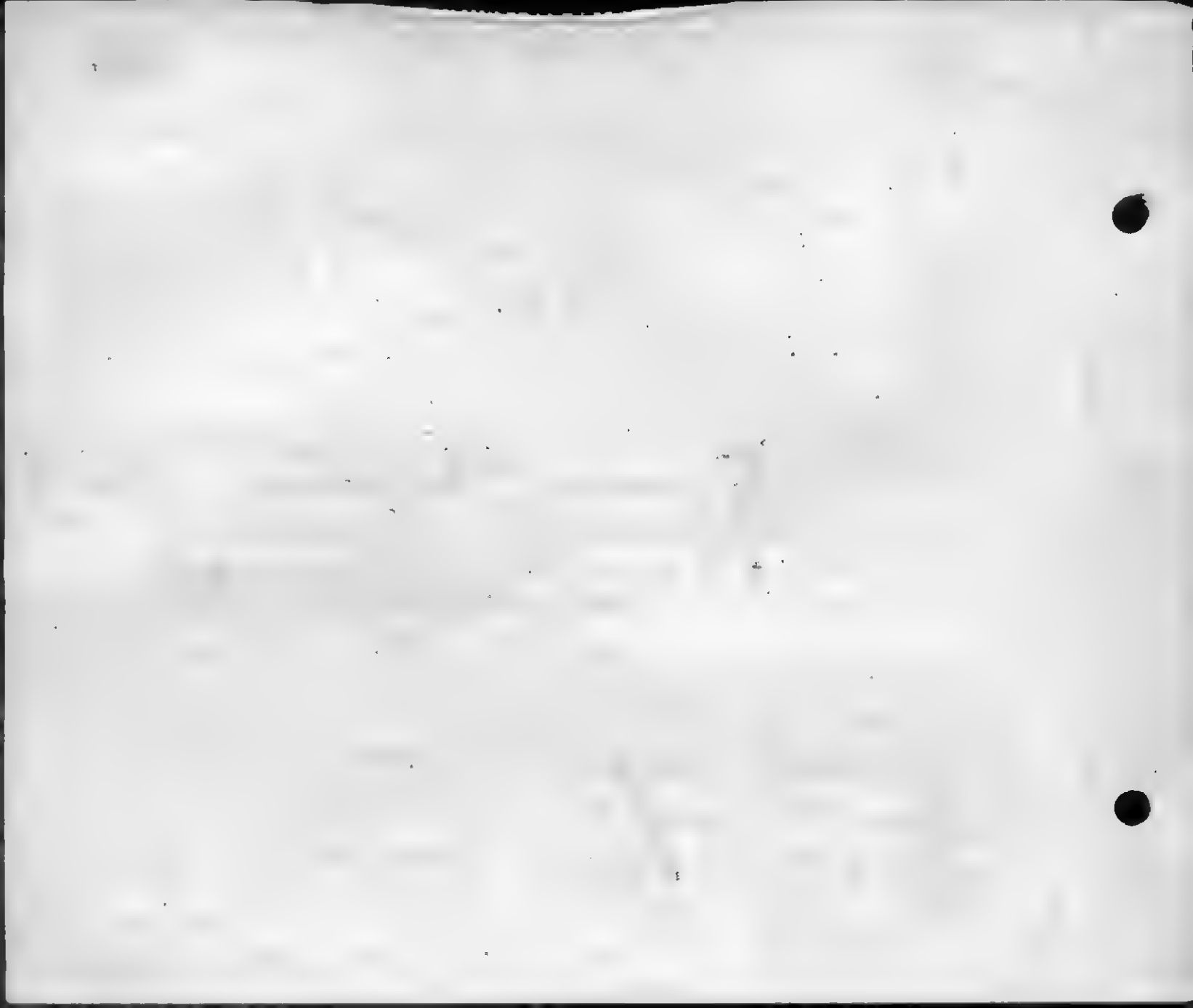
TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15307						15306					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>Baltimore</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			a. STATE <b>MARYLAND</b>			b. COUNTY <b>Baltimore</b>		
c. LENGTH OF STAY IN ID <b>6 Days</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>			d. STREET ADDRESS <b>7213 North Point Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>						f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elsie Jane Kerr</b>			4. DATE OF DEATH <b>11 - 5 - 1966</b>			5. SEX <b>F</b>			6. COLOR OR RACE <b>W</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>8-02-09</b>			9. AGE (In years last birthday) <b>57 yrs.</b>			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Martin Kerr</b>			14. MOTHER'S MAIDEN NAME <b>Showers, Ida Mae</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>298-03-0485</b>		
17. INFORMANT <b>Patient</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest; repeated</b> + 71X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>aspiration pneumonia</b> DUE TO (c) <b>post-compensatory &amp; neck diverting</b>			INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11-5</b> p.m. <b>11-5</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (1) (this hospital) attended the deceased from <b>10/30</b> , 19 <b>66</b> , to <b>Nov 5</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>11-5</b> 19 <b>66</b> , and that death occurred at <b>11:20</b> a.m. from the causes and on the date stated above.			22a. SIGNATURE <b>E.A. GEDOSH</b>		
22b. DATE SIGNED <b>11-5-66</b>			22c. PHYSICIAN'S NAME (Type or print) <b>E.A. GEDOSH</b>			22d. ADDRESS <b>Greater Baltimore Medical Center</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		
23b. DATE THEREOF <b>Nov. 8-1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>			23d. LOCATION (City, town or county) (State) <b>Dorsey, Maryland</b>			24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		
25a. REC'D BY REGISTRAR <b>NOV 10 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c. DATE			25d. TIME		









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

# MARYLAND STATE DEPARTMENT OF HEALTH

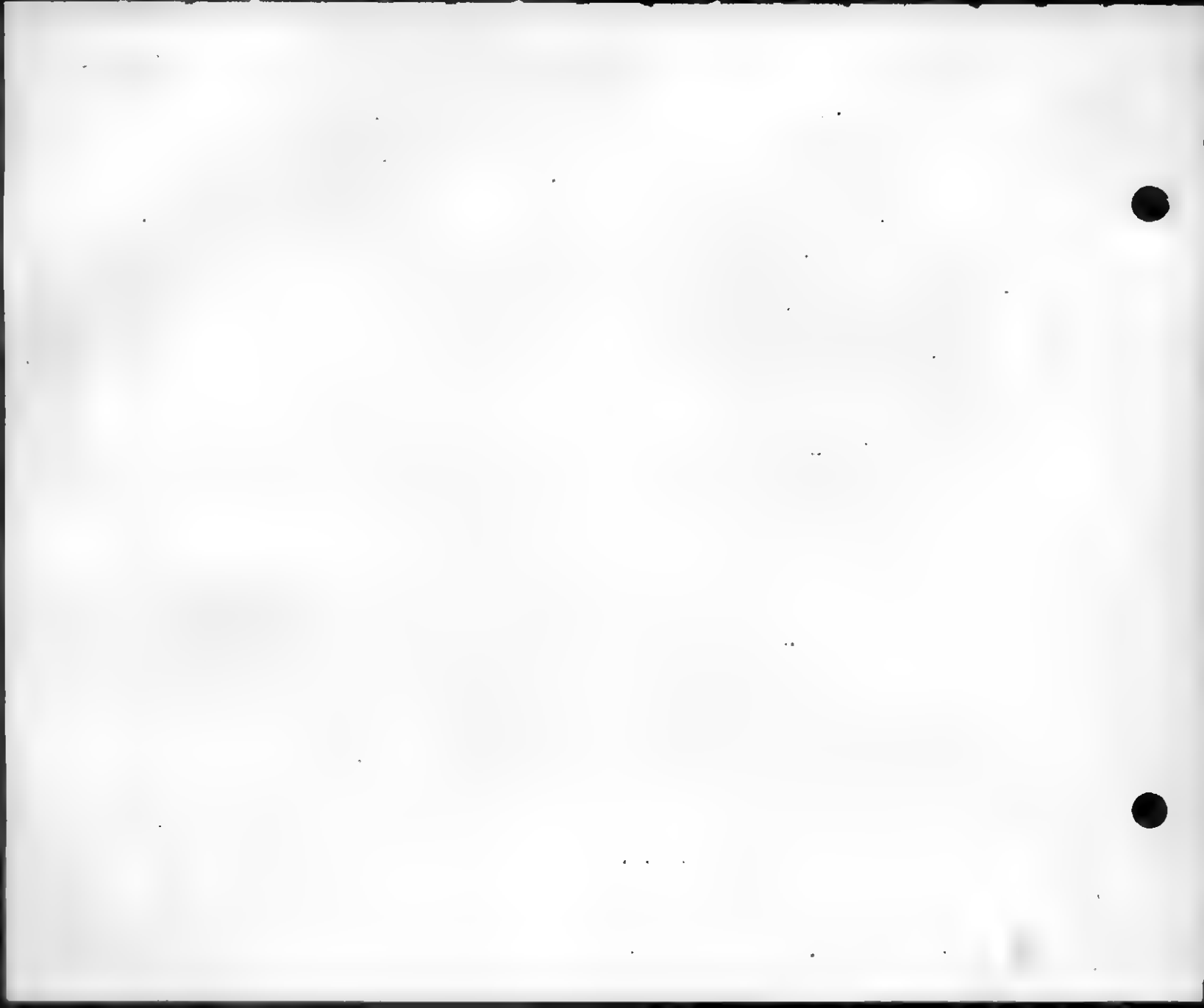
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15309

## CERTIFICATE OF DEATH

15308

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>6 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>1613 West Lexington St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>KING</b> Last <b>KING</b>				4. DATE OF DEATH Month <b>11</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-19-50</b>	
9. AGE (In years last birthday) <b>16</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		9. AGE (In years last birthday) <b>16</b> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Lee King</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MICROCEPHALY</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>7/14</b> , 19 <b>60</b> , to <b>11/29</b> , 19 <b>66</b> , that <b>th</b> (we) last saw the deceased alive on <b>11/29</b> , 19 <b>66</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip Zieve</b>				22b. DATE SIGNED <b>11/29/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Philip Zieve, M.D.</b>	
22d. ADDRESS <b>Rosewood State Hosp., Owings Mills, Md.</b>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood</b>		23d. LOCATION (City, town or county) (State) <b>Owings Mills Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. ELIN &amp; Sons Tristestown Md</b>				25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



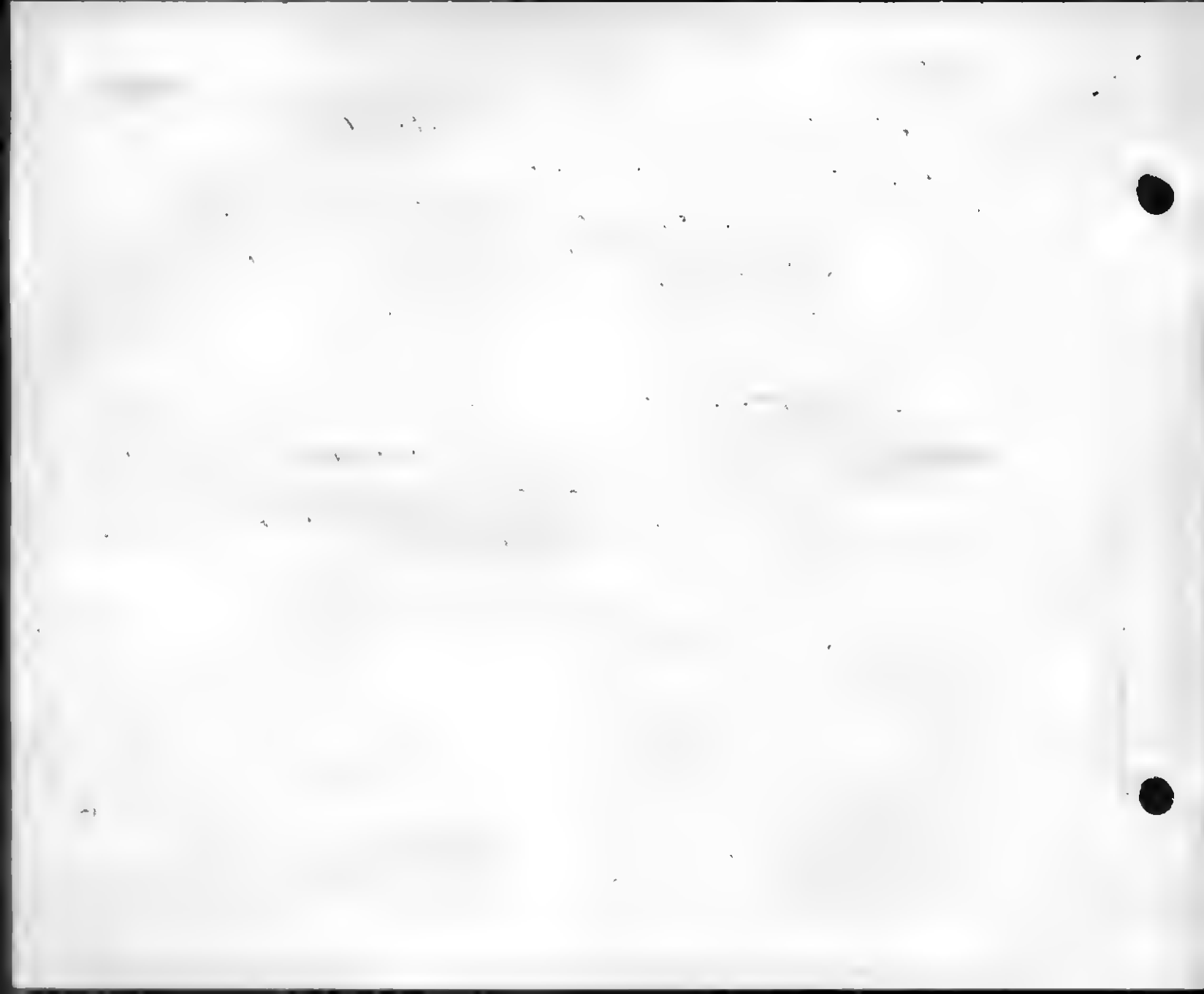
15310

CERTIFICATE OF DEATH

15309

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. LENGTH OF STAY IN TB <b>21 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTO. COUNTY GEN. HOSPITAL</b>		e. STREET ADDRESS <b>6819 TOWNBROOK DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>JULIUS (Hugo) KIRCHHAUSEN</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 20, 1981</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13. FATHER'S NAME <b>MAX KIRCHHAUSEN</b>		14. MOTHER'S MAIDEN NAME <b>JOHANNA PAPPENHEIMER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>MM-26-0423</b>	
17. INFORMANT <b>ELSA KIRCHHAUSEN</b>		Address <b>6819 TOWNBROOK</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY THROMBOSIS</b> DUE TO (b) <b>ONE DAY</b> DUE TO (c) <b>ONE DAY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UREMIA SECONDARY TO OBSTRUCTIVE UROPATHY</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-5, 1966</b> , to <b>11-26, 1966</b> , that (I) (we) last saw the deceased alive on <b>11-26, 1966</b> and that death occurred at <b>12:25 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Quentin L. Lly</b>		22b. DATE SIGNED <b>11-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>QUINTIN L. LLY</b>		22d. ADDRESS <b>BALTO. COUNTY GEN. HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cheverre Ahasas Chessed</b>	23d. LOCATION (City or Town) (County) (State) <b>Randallstown, Maryland</b>
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15311

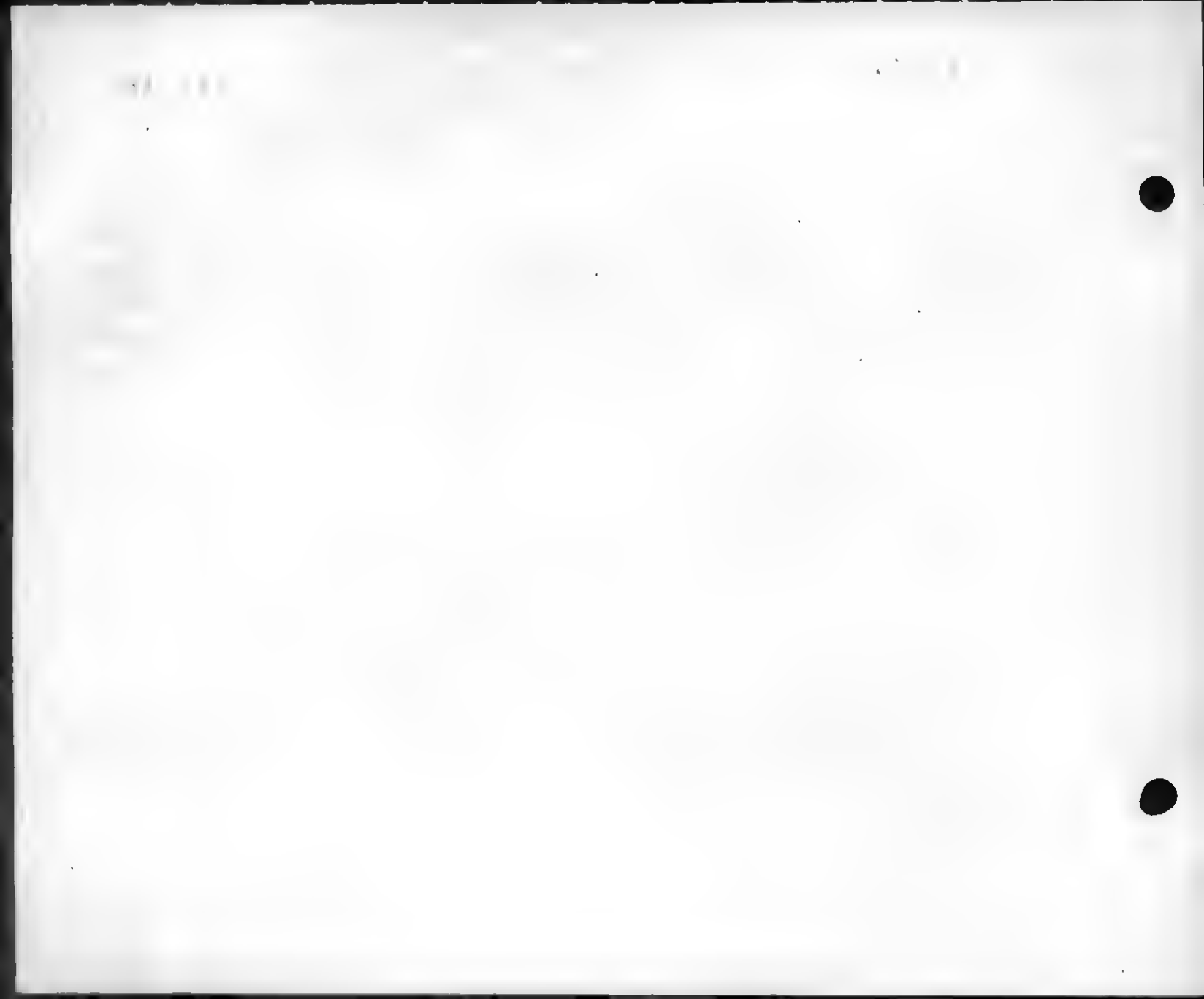
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15311

1 PLACE OF DEATH a COUNTY <b>BALTO</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MD</b> b COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX 03-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>364 NICHOLSON RD.</b>		d. STREET ADDRESS <b>364 NICHOLSON RD</b>	
3 NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>KOMOROWSKI</b> Middle <b>SR.</b> Last		4. DATE OF DEATH Month <b>Nov</b> Day <b>22</b> Year <b>1966</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAY 10, 1911</b>
9 AGE (In years last birthday) <b>55</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>DETECTIVE</b>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>US IT</b>	
13 FATHER'S NAME <b>KONSTANTIOS KOMOROWSKI</b>		14 MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNK</b>		16 SOCIAL SECURITY NO <b>216-01-2198</b>	
17 INFORMANT <b>WIFE</b>		Address <b>ABOVE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>P-S-C-V-Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first! (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>pm</b> 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS</b> MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800</b>	
		Address (Street, city, town, or county) <b>MORNINGTON RD</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/25/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>	23d LOCATION (City or Town) (County) (State) <b>BALTO MD</b>
24 FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>		25a REC'D BY REGISTRAR <b>NOV 23 1966</b>	
ADDRESS <b>300 MACE</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

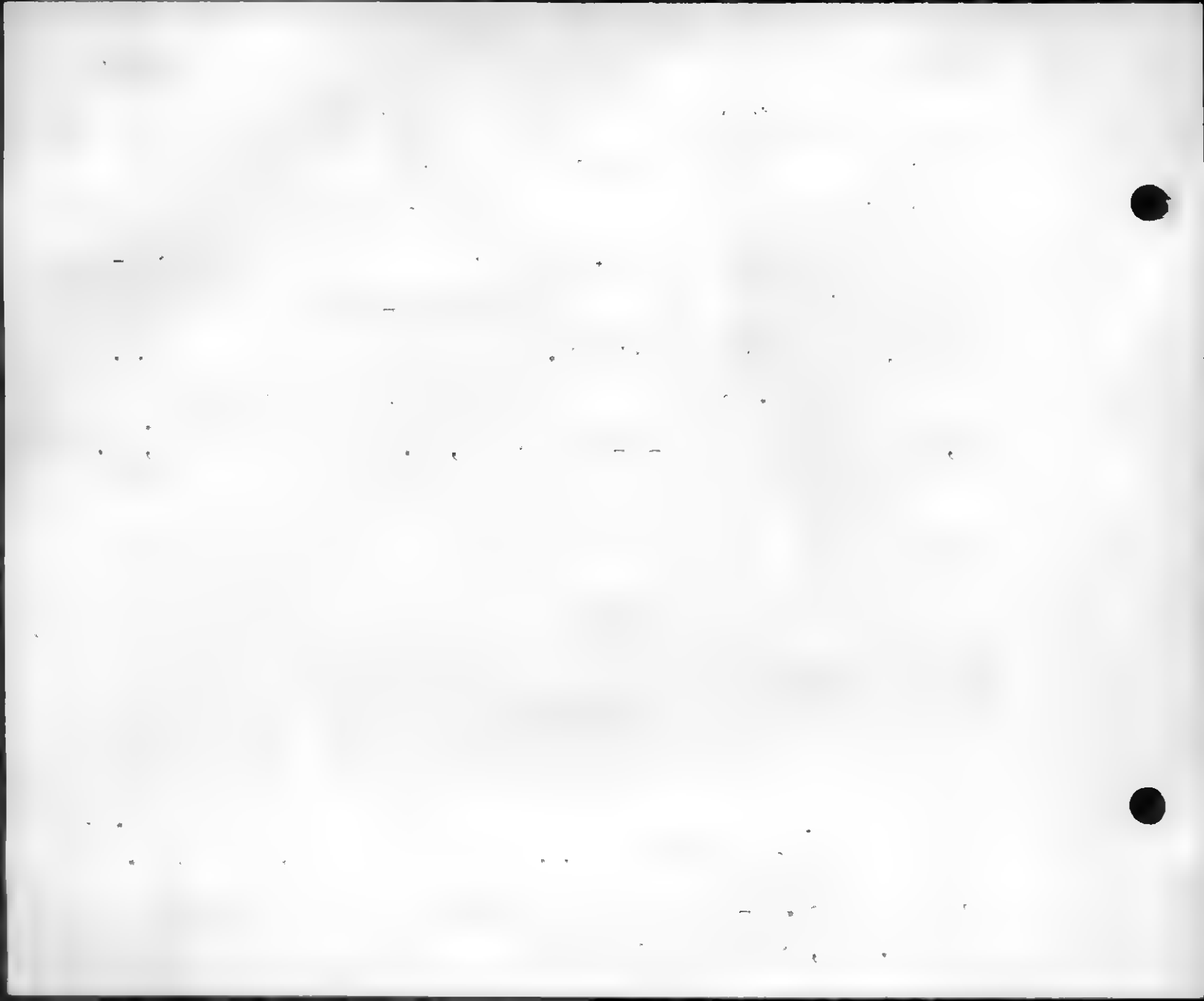
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15312

## CERTIFICATE OF DEATH

15311

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>40 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>27 Portship Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>1789 Brookview 21222</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>M.</b> Last <b>Krahn</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>19 66</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15- 1910</b>		9. AGE (In years last birthday) <b>56</b> yrs.		10. FINDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.													
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Henry M. Krahn</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Kraming</b>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes, Army WWII</b>				16. SOCIAL SECURITY NO. <b>216-05-1136</b>				17. INFORMANT <b>Brother, Mr. Frank Krahn, Dundalk, Md. 21222</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Cirrhosis of the liver, advanced</b> DUE TO (c) <b>1 1/2 year</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days</b>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 1965, to <b>Nov 7</b> , 1966, that (I) (we) last saw the deceased alive on <b>Nov. 6</b> , 1966, and that death occurred at <b>5:10 A.M.</b> from the causes and on the date stated above.																											
22a. SIGNATURE <b>Ataollah Golpira</b> M.D.				22b. DATE SIGNED <b>Nov. 7-1966</b>				22c. PHYSICIAN'S NAME (Type) <b>Ataollah Golpira</b> M.D.				22d. ADDRESS <b>1942 Cedar Lane, Dundalk, Md. 21222</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov. 9-1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>				23d. LOCATION (City, town or county) (State) <b>Dorsey, Maryland</b>															
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>				25a. REC'D BY REGISTRAR <b>NOV 10 1966</b>				25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>																			





FOR STATE  
HEALTH DEPT

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

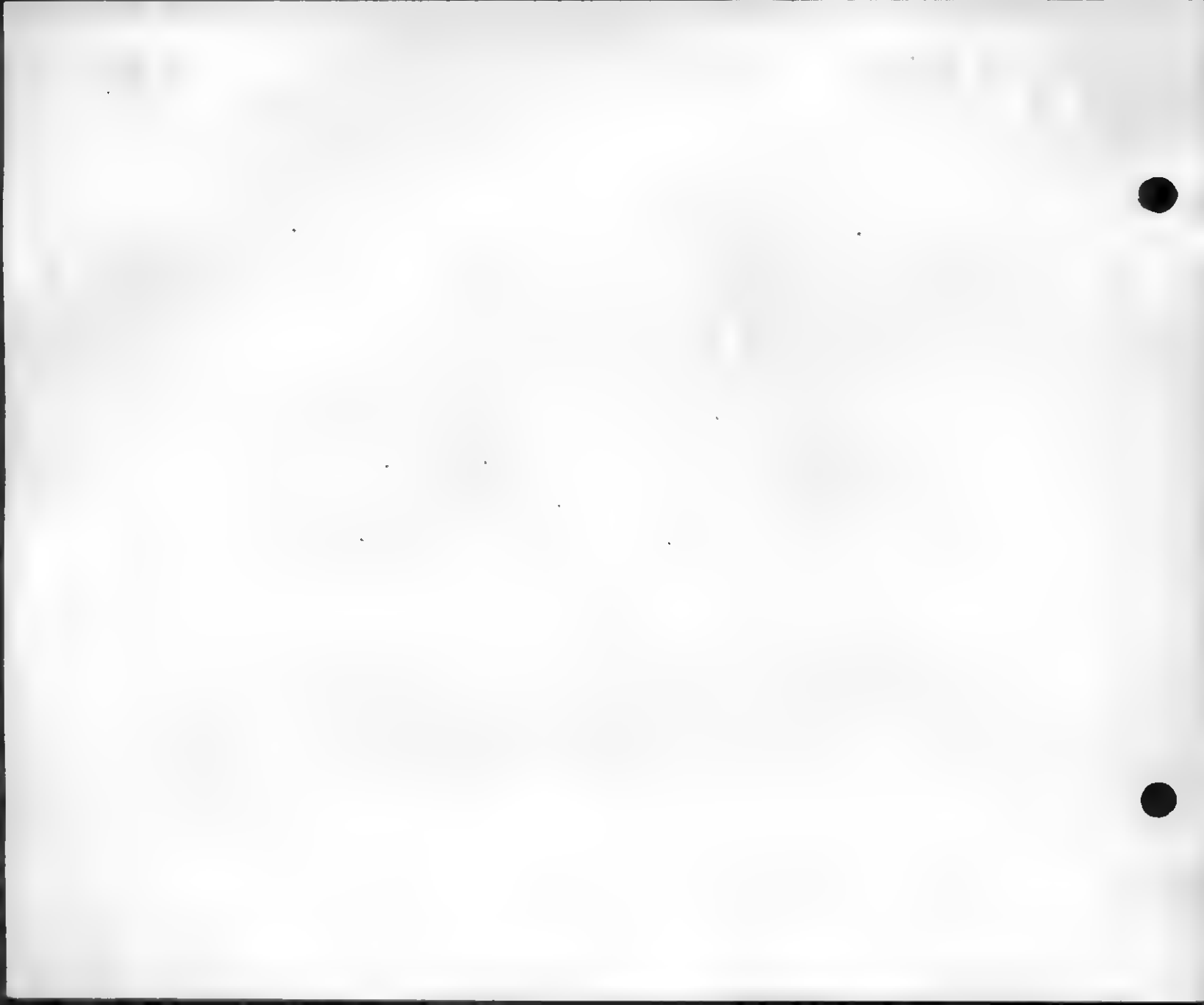
VR A15ME (5)  
6M 1/66

15313

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15312

PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN TB		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital 7620 York Road</b>		e STREET ADDRESS <b>7920 Millendale Road 34</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Lacroix</b> Last <b>Lacroix</b>		4 DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1966</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/4/04</b>	9 AGE (In years last birthday) yrs <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Civil Service</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Edgewood</b>		11 BIRTHPLACE (State or foreign country) <b>Richmond Va.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>William W. Archer</b>		14 MOTHER'S MAIDEN NAME <b>Blanche V. Archer UK</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO		17. INFORMANT Address <b>34</b> <b>Mr Joseph L. Lacroix 7920 Millendale Road</b>	
18 CAUSE OF DEATH (Enter on y one cause per ne for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		<b>Acute Pulmonary Edema</b> <b>Chronic Congestive Failure</b> <b>due to Abdominal Cramping</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		20g (County)		20h (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		M.D.		22. DATE SIGNED <b>11/6/66</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		Address (Street, city, town, or county)			
23a BURIAL (CREMATION, REMOVAL) (Specify) <b>burial</b>		23b. DATE THEREOF <b>11-9-1966</b>		23c NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23d LOCATION (City or Town) <b>Baltimore</b>		23e (County) <b>md.</b>		23f (State) <b>md.</b>	
24. FUNERAL DIRECTOR <b>Lassahn Park/Hon. 7401 Belair Rd</b>		ADDRESS		25a REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

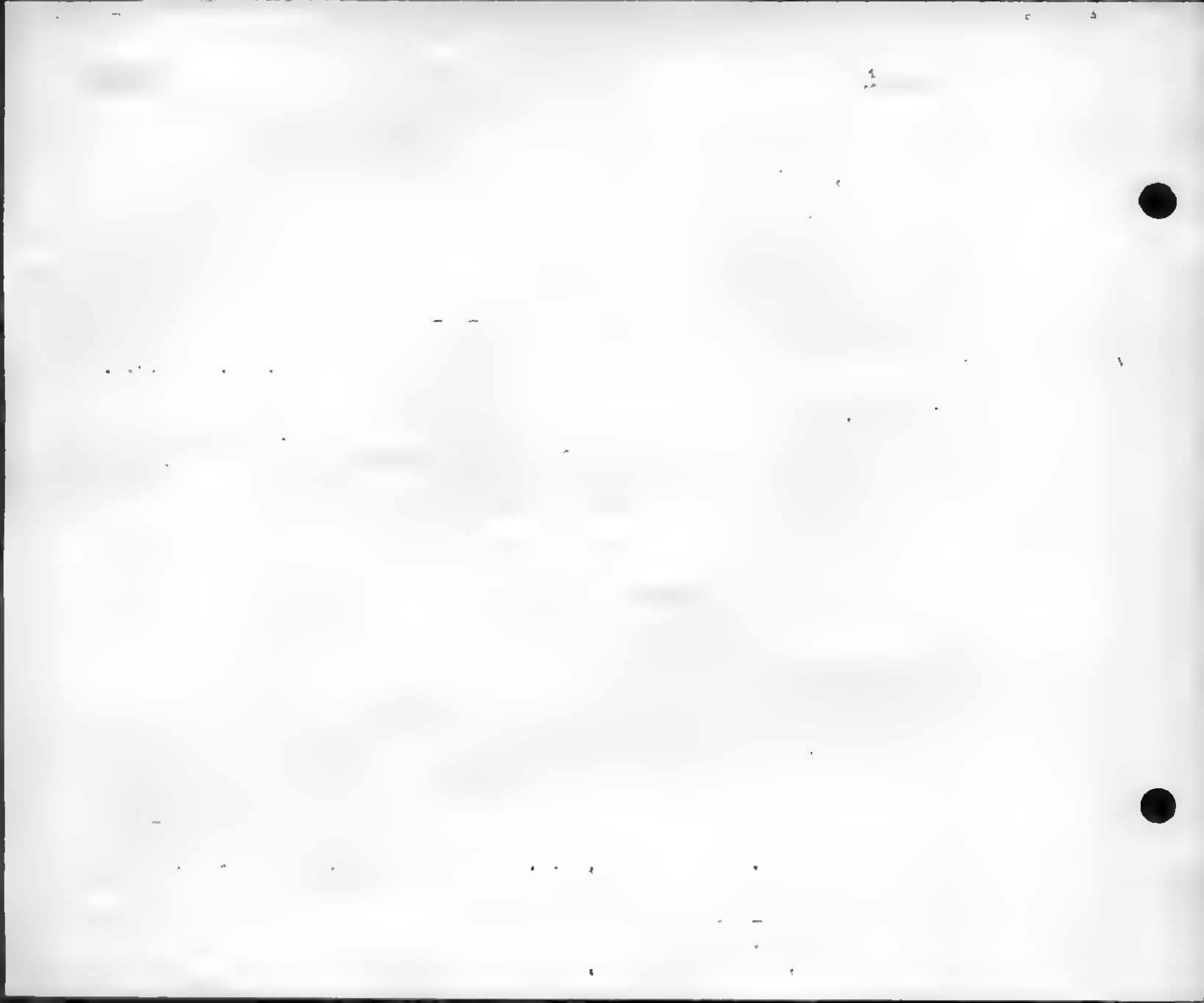
15314

15313

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>		c LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>4309 PARK HEIGHTS AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>DORSEY</b> Middle <b>CLYDE</b> Last <b>LAKE</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-27-22</b>
9 AGE (In years last birthday) <b>44</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b KIND OF BUSINESS OR INDUSTRY <b>RESTURANT</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>W. VA.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER W. LAKE</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE (Unknown)</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WWII</b>		16 SOCIAL SECURITY NO <b>723 07 89 35</b>	
17 INFORMANT <b>VA HOSPITAL CLINICAL RECORDS</b>		<b>FORT HOWARD, MARYLAND</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>INFARCTION OF BRAIN</b> DUE TO (c) <b>THROMBOSIS OF RIGHT CAROTID ARTERIES</b>			INTERVA. BETWEEN DEATH AND DEATH <b>MINUTES</b> <b>DAYS</b> <b>DAYS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOV 2</b> , 19 <b>66</b> , to <b>NOV 6</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV 6</b> , 19 <b>66</b> , and that death occurred at <b>115A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>M.D. Barhanpurkar</b>		22b. DATE SIGNED <b>11-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11 - 9 - 66</b>	23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG</b> ADDRESS <b>FUNERAL HOME INC, 6009 HARFORD RD, BALTIMORE</b>		25a. RECD BY REGISTRAR DATE <b>NOV 7 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

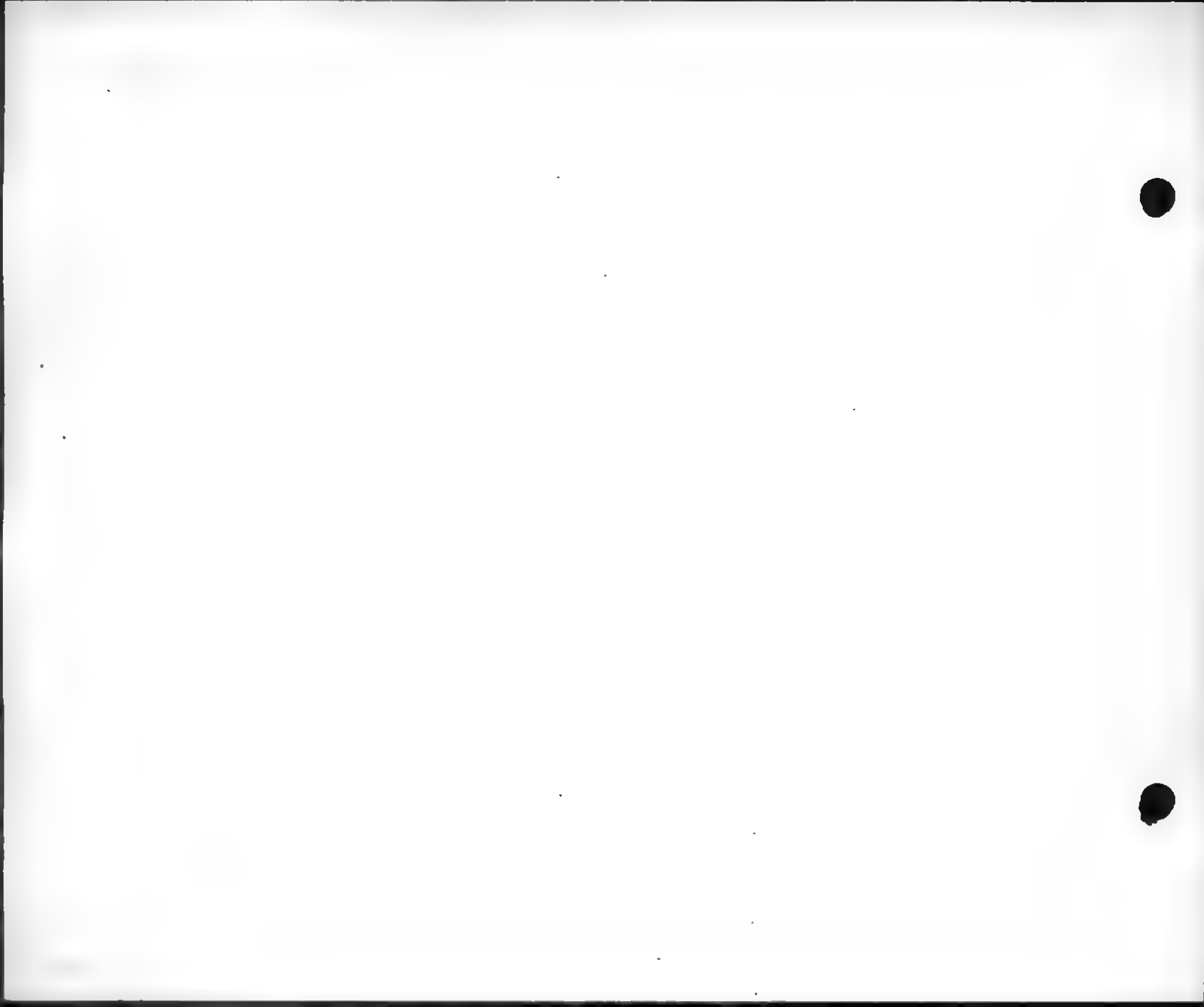
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15315

15314

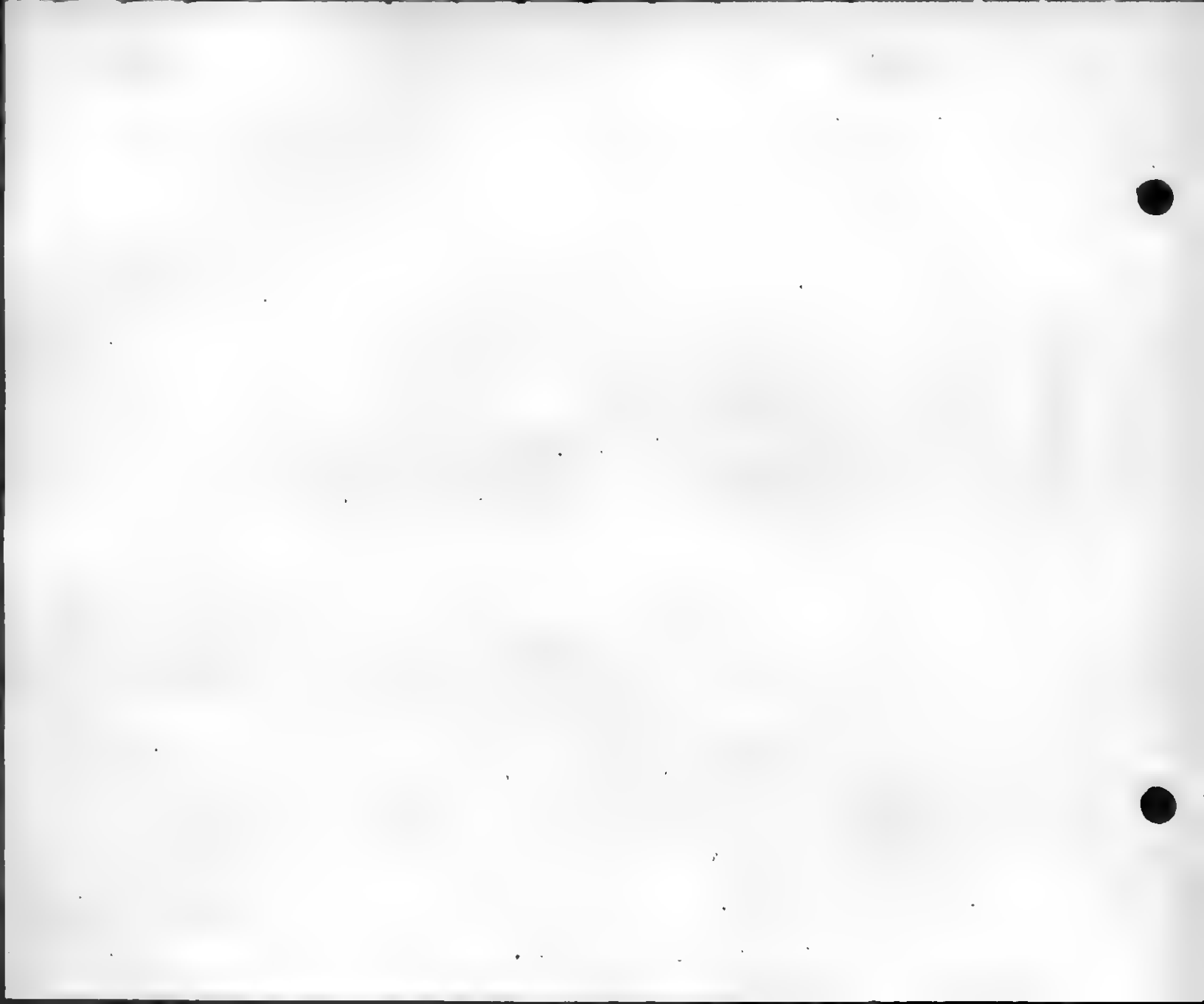
1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Dundalk</b>		c LENGTH OF STAY IN 'b <b>13 Yrs.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3948 Old North Point Road</b>		d STREET ADDRESS <b>3948 Old North Point Road</b>	
3 NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>A.</b> Last <b>LAUBACH</b>		4 DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/21/21</b>
9 AGE (In years last birthday) <b>45</b> yrs		10 IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>John Hearl</b>		14 MOTHER'S MAIDEN NAME <b>Maggie Green</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>212-42-6376</b>	
17 INFORMANT (Husband) <b>Edwin Laubach, 3948 Old North Point Rd.</b>		Address <b>Dundalk, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>12910</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Drowning</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy.</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Drowned in bath tub</b>	
20c TIME OF INJURY Month, Day, Year hour <b>11/2</b> pm <b>19 66</b>	20d INJURY OCCURRED Where <input type="checkbox"/> of work <input type="checkbox"/> Hot <input type="checkbox"/> White <input checked="" type="checkbox"/> of work	20e PLACE OF INJURY (Home farm factory street office b.d.g., etc.) <b>Home</b>	20f (City or town) (County) (State) <b>Dundalk Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		22. DATE SIGNED <b>11/3/66</b>	
23a BURIAL, CREMATION REMOVAL, (Specify) <b>Burial</b>		23b DATE THEREOF <b>3/5/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>
23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 4 1966</b>	
24 FUNERAL DIRECTOR <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>M</p> </div> <div> <p>15316</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15315</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney-Towson Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5211 Loch Raven</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CLARENCE</u> First <u>G.</u> Middle <u>Lehr</u> Last			4. DATE OF DEATH <u>Nov.</u> Month <u>24</u> Day <u>19</u> Year <u>66</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>MAY 19 1881</u>			9. AGE (in years last birthday) <u>85</u> yrs.			IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Louis Lehr</u>						14. MOTHER'S MAIDEN NAME <u>Mary Steinmiller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212 22 774</u>		17. INFORMANT <u>John L. Lehr-1536</u> Address <u>Rennewick Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4121</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rt. common Iliac Artery Thrombosis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>July</u> , 19 <u>62</u> , to <u>Nov 24</u> , 19 <u>66</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Nov 20</u> 19 <u>66</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Alfred G. Ossman Jr</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>11-24-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Alfred G. Ossman Jr M.D.</u>						22d. ADDRESS <u>1010 St Paul St. Baltimore 2 Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BAITIMORE Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.</u>				ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15317

15316

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Professors House</u>				d. STREET ADDRESS <u>3507 Shelburne Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Juliette Meyer Levi</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/7</u> yrs.	
9. AGE (In years) <u>77</u> yrs.		10. FINDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>	
13. FATHER'S NAME <u>Simon Nathan Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Franne?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Joseph R. Levi</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO (b) <u>arteriosclerotic C.V.D.</u> DUE TO (c) <u>hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 weeks</u> <u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphoscoliotic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7</u> , 19 <u>66</u> , to <u>11/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>66</u> , and that death occurred at <u>11</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert Levi</u>				22b. DATE SIGNED <u>11/7/66</u>		22c. PHYSICIAN'S NAME (Type) <u>J. ELIOT LEVI</u>	
22d. ADDRESS <u>222 W. Cold Spring Lane</u>				22e. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>Nov 7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Sol Leunow &amp; Sons - 6010 Reisterstown Rd</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

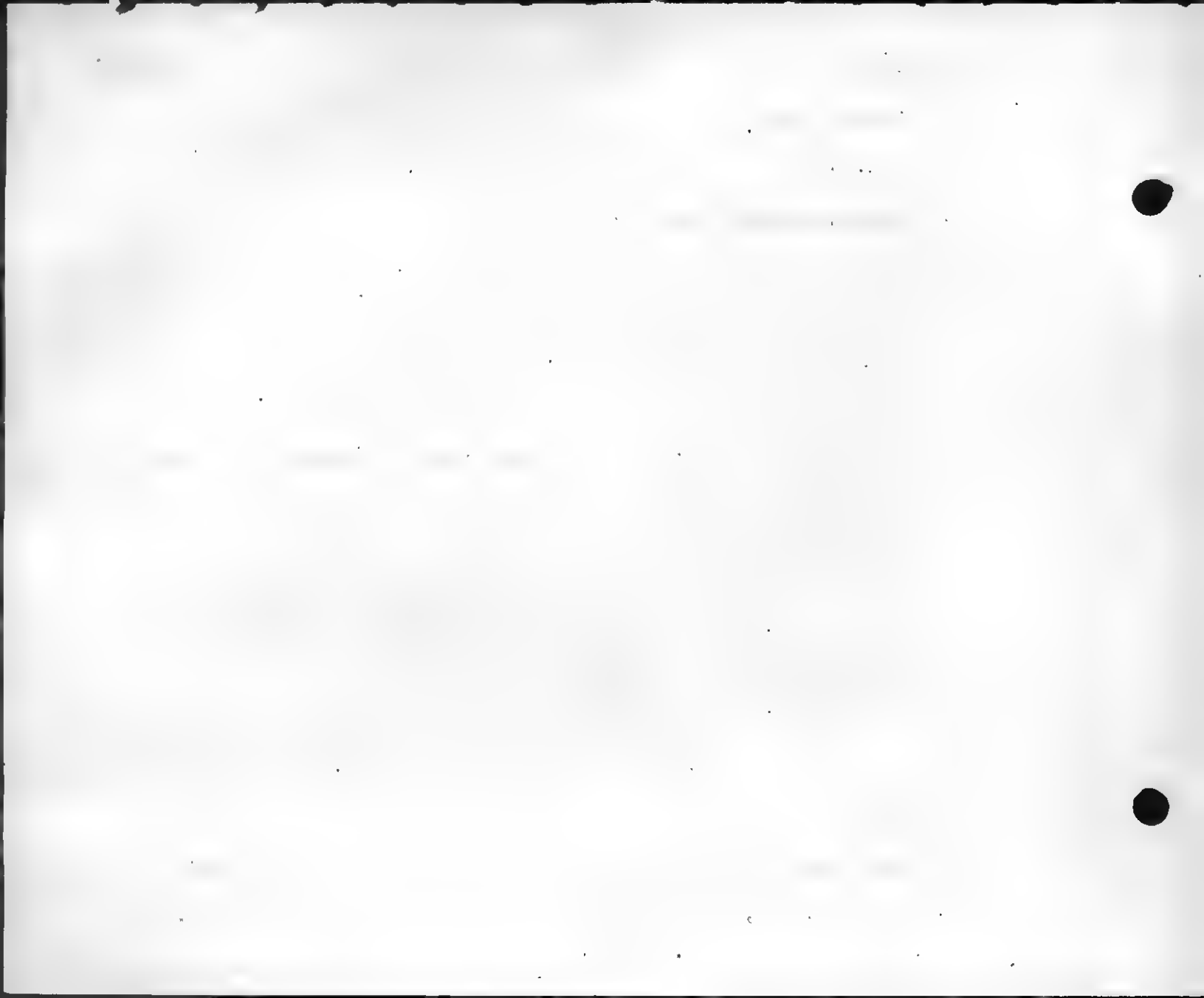


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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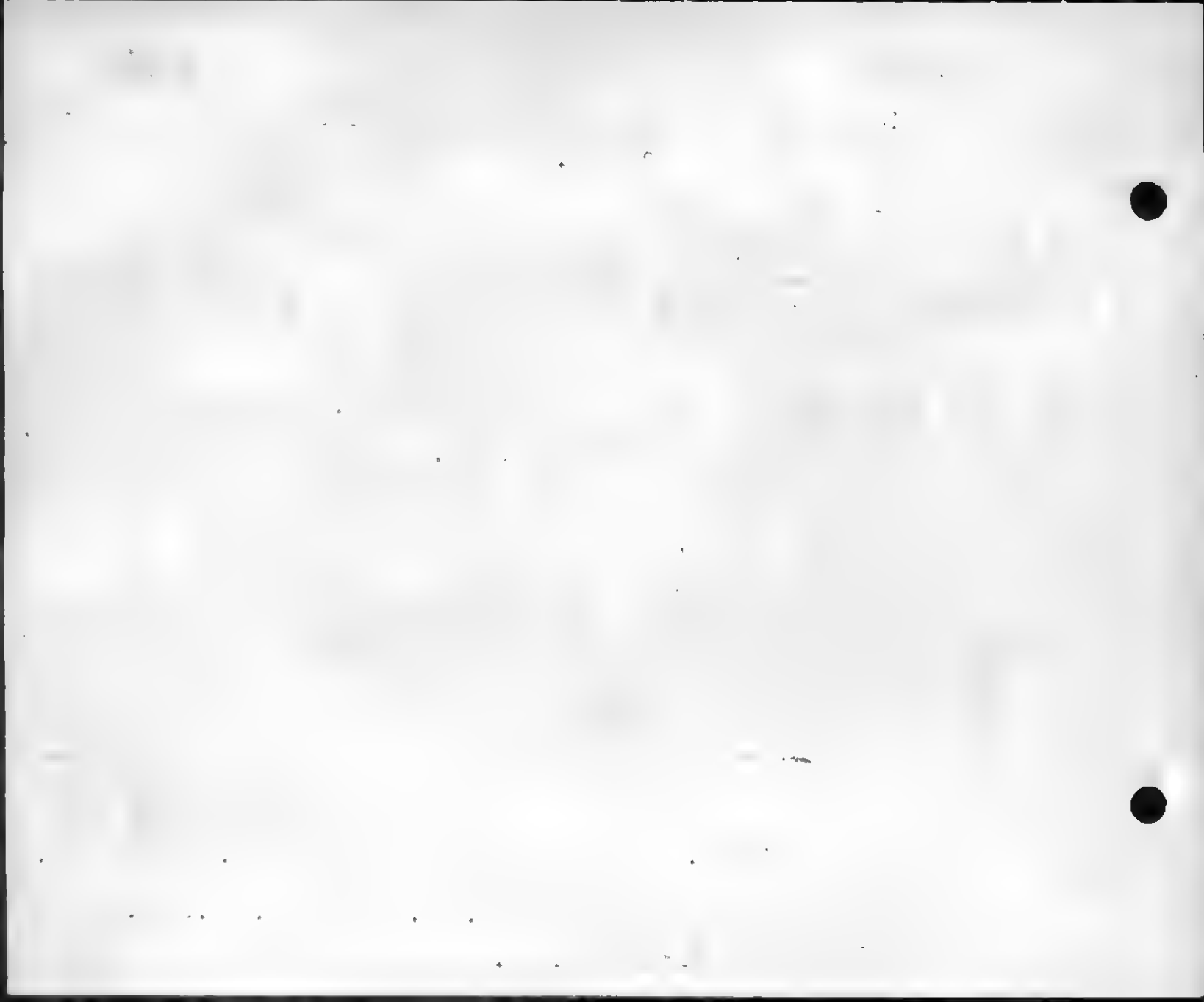
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> <b>COUNTY</b> <b>Baltimore County</b>		<b>MARYLAND</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</b> <b>a. STATE</b> <i>Darkeed</i> <b>b. COUNTY</b> <i>Baltimore</i>					
<b>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</b> <b>Mount Wilson</b>		<b>c. LENGTH OF STAY IN 1b</b>		<b>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</b> <i>Baltimore City</i>					
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <b>Mount Wilson State Hospital</b>				<b>d. STREET ADDRESS</b> <i>1707 Jackson St</i>				<b>e. IS RESIDENCE ON A FARM?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>3. NAME OF DECEASED (Type or print)</b> <i>Ralph</i>		<b>First</b>		<b>Middle</b>		<b>Last</b>		<b>4. DATE OF DEATH</b> <b>Month</b> <i>11</i> <b>Day</b> <i>23</i> <b>Year</b> <i>1966</i>	
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>W.</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>6-12-98</i>		<b>9. AGE (In years last birthday)</b> <i>68</i> yrs.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <i>Mail clerk</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Insurance company</i>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <i>Illinois</i>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>US</i>	
<b>13. FATHER'S NAME</b> <i>Henry Lindner</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Kathleen Stutz</i>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <i>yes</i>		<b>16. SOCIAL SECURITY NO.</b> <i>218-28-0896</i>		<b>17. INFORMANT</b> <b>Records, Mt. Wilson State Hospital</b>				<b>Address</b>	
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Carcinoma, right lung</i> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST,</b> <b>DUE TO (b)</b> <b>DUE TO (c)</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <i>Far advanced pulmonary tuberculosis</i>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>10-12</i> , 19 <i>66</i> , <b>to</b> <i>11-23</i> , 19 <i>66</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>11-23 1966</i> , <b>and that death occurred at</b> <i>6:45</i> AM, <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>Wm. Newcomer</i>				<b>22b. DATE SIGNED</b>				<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wm. Newcomer, M.D., Superintendent</b>	
<b>22d. ADDRESS</b> <b>Mount Wilson, Maryland</b>				<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22f. M.D.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11 26, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Montgomery Chapel</b>		<b>23d. LOCATION (City, town or county)</b> <b>Montgomery Co., Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Mc Cully</b>				<b>ADDRESS</b> <b>130 E. Fort Ave</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <i>NOV 28 1966</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15319					15318				
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN ID <b>30 YRS.+</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7036 BELCLARE ROAD</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD...</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 21222</b> d. STREET ADDRESS <b>7036 BELCLARE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ANNA LEHN LOCK</b>			4. DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>1966</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>2/24/1912</b> 9. AGE (in years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR Months Oays Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN LEHN</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH W. HEIMMERDINGER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ANNA C. CASTIGLIONE, DUNDALK, MD.</b> Address <b>212 DETROIT AVE.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Malignant Hypertension</b> DUE TO (c) <b>Obesity</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>10-19</b> , 19 <b>59</b> , to <b>11-4</b> , 19 <b>66</b> , that (I) <del>(the hospital)</del> last saw the deceased alive on <b>11-4</b> , 19 <b>66</b> , and that death occurred at <b>A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Eugene F. Nevy</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>11/5/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>EUGENE F. NEVY</b>					22d. ADDRESS <b>7001 MORNINGTON RD. DUNDALK, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>11/7/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM. PK.</b>			23d. LOCATION (City, town or county) (State) <b>BALTO. CO., MD.</b>	
24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY, DUNDALK, MD.</b>					25a. REC'D BY REGISTRAR <b>NOV 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

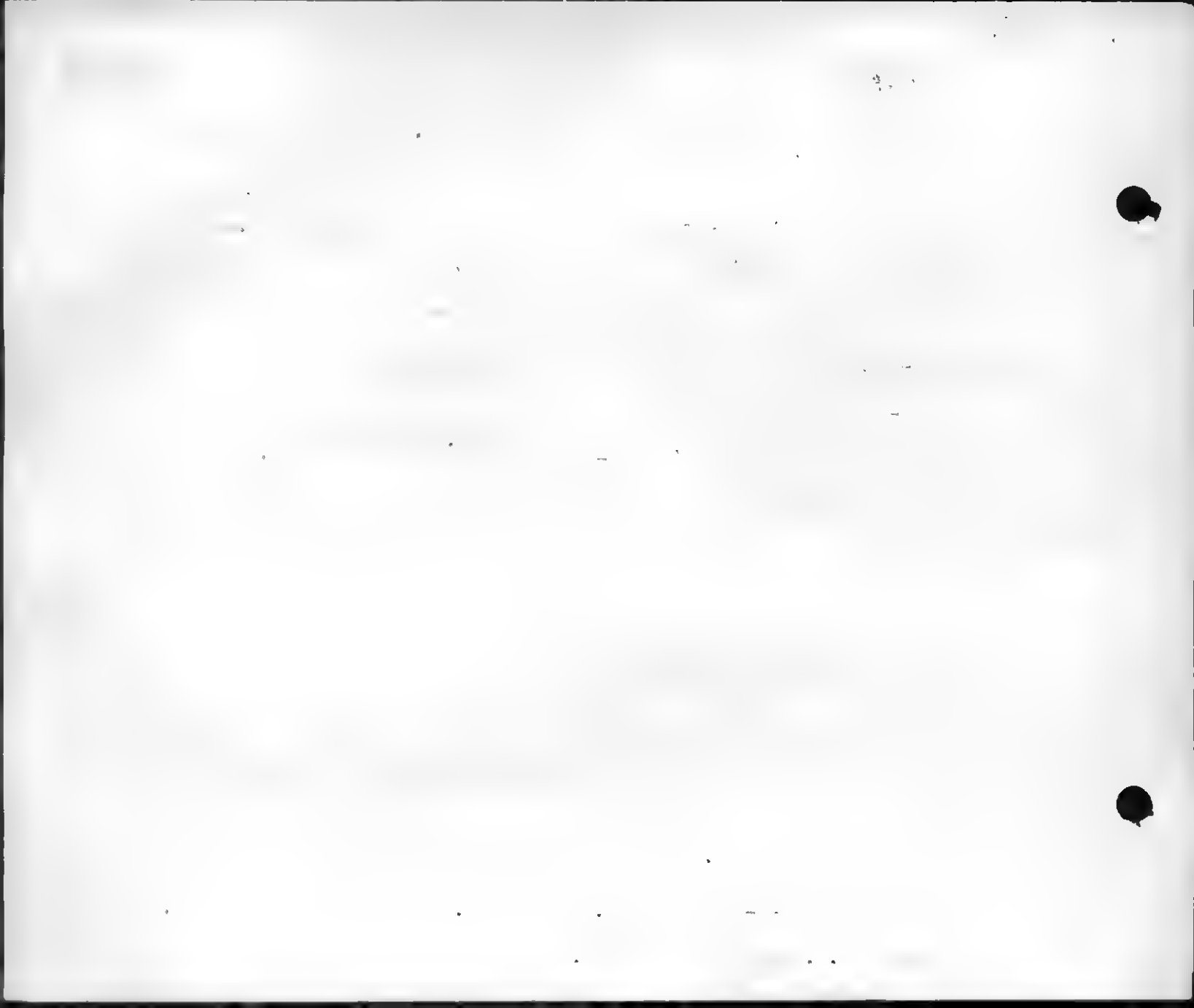
15320

15319

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6518 Woodbridge Circle-Westview</b>		d. STREET ADDRESS <b>6518 Woodbridge Cir.-Westview</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emil</b> Middle <b>Loetz</b> Last <b>Loetz</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-21-91</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	11. IF UNDER 24 HRS Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret-Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Late-Robert Loetz</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>805-05-3540 R</b>	
17. INFORMANT <b>Mrs. Rose Loetz</b>		Address <b>6518 Woodbridge Cir. - Westview</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 22, 1957</b> to <b>Nov 30, 1966</b> , that (I) (we) saw the deceased alive on <b>Nov. 29, 1966</b> , and that death occurred at <b>9:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Harry L. Knipp</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-30-66</b>
22c. PHYSICIAN'S NAME (Type) <b>Harry L. Knipp M.D.</b>		22d. ADDRESS <b>4116 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-3-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



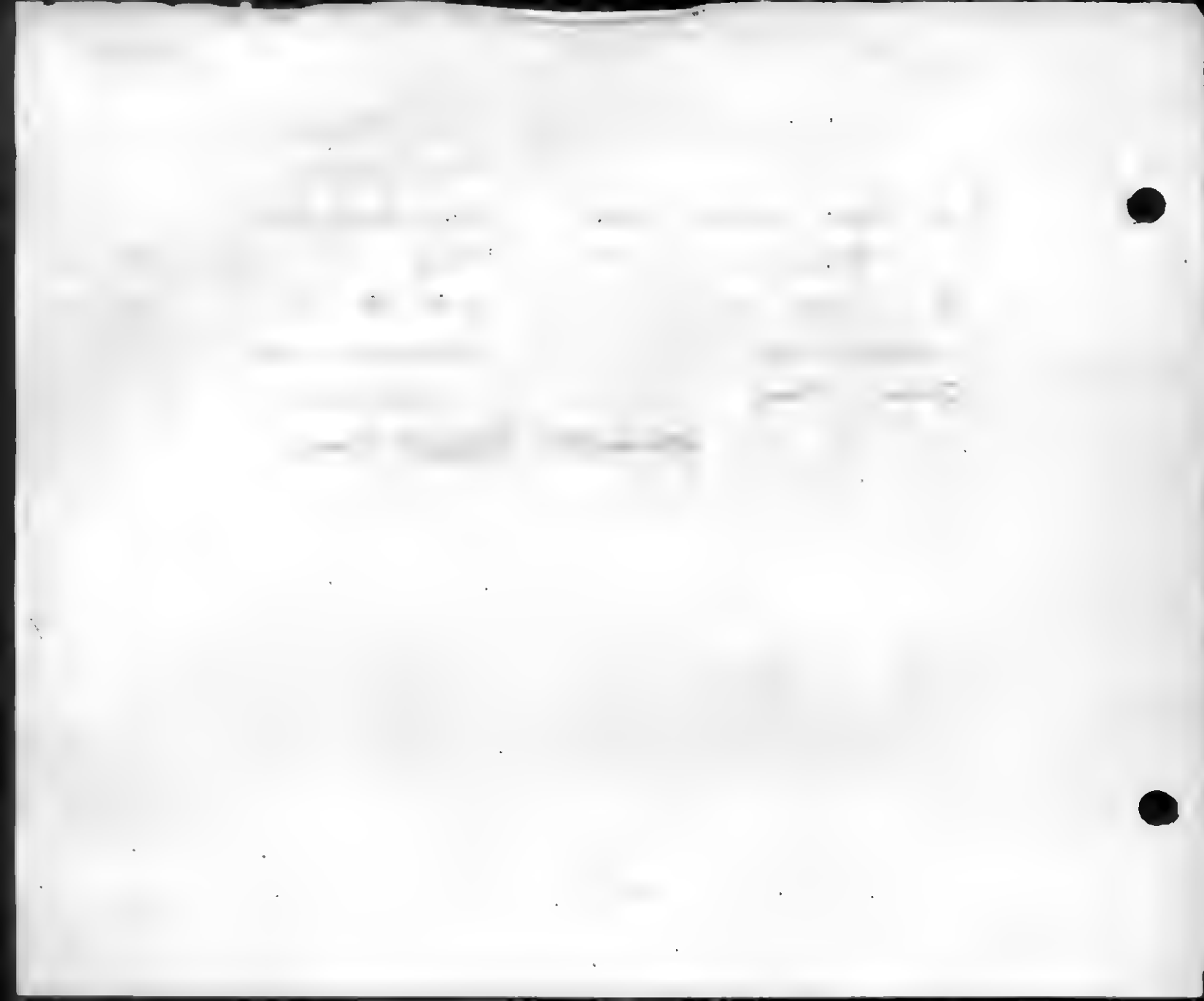


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15321					15320				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE				
Baltimore MARYLAND					Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Baltimore					Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Greater Balto Medical Center					4211 Penn Ave.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
Margaret M Long.					Month 11 Day 22 Year 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-4-89		77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
House wife					Baltimore md.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John May					unknown ANNA PRELLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
NO					220-14-5475				
17. INFORMANT					Address				
Patient's Chart.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure									
151X DUE TO (b) Obstructive jaundice									
DUE TO (c) Carcinoma of head of pancreas									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
Hour a.m. 19 p.m.					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Oct. 24, 1966, to Nov. 22, 1966, that (I) (we) last saw the deceased alive on Nov. 22, 1966, and that death occurred at 4 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Robert W. Smith					11-22-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
ROBERT W. SMITH					GREATER BALTO MEDICAL CENTER				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)	
BURIAL			11/25/66		PARKWOOD CEM.			TAYLOR AVE MD	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
DIPPEL BRUNG					25b. REGISTRAR'S SIGNATURE				
THE BELAIR RD					Charles Judge				
DATE NOV 23 1966									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

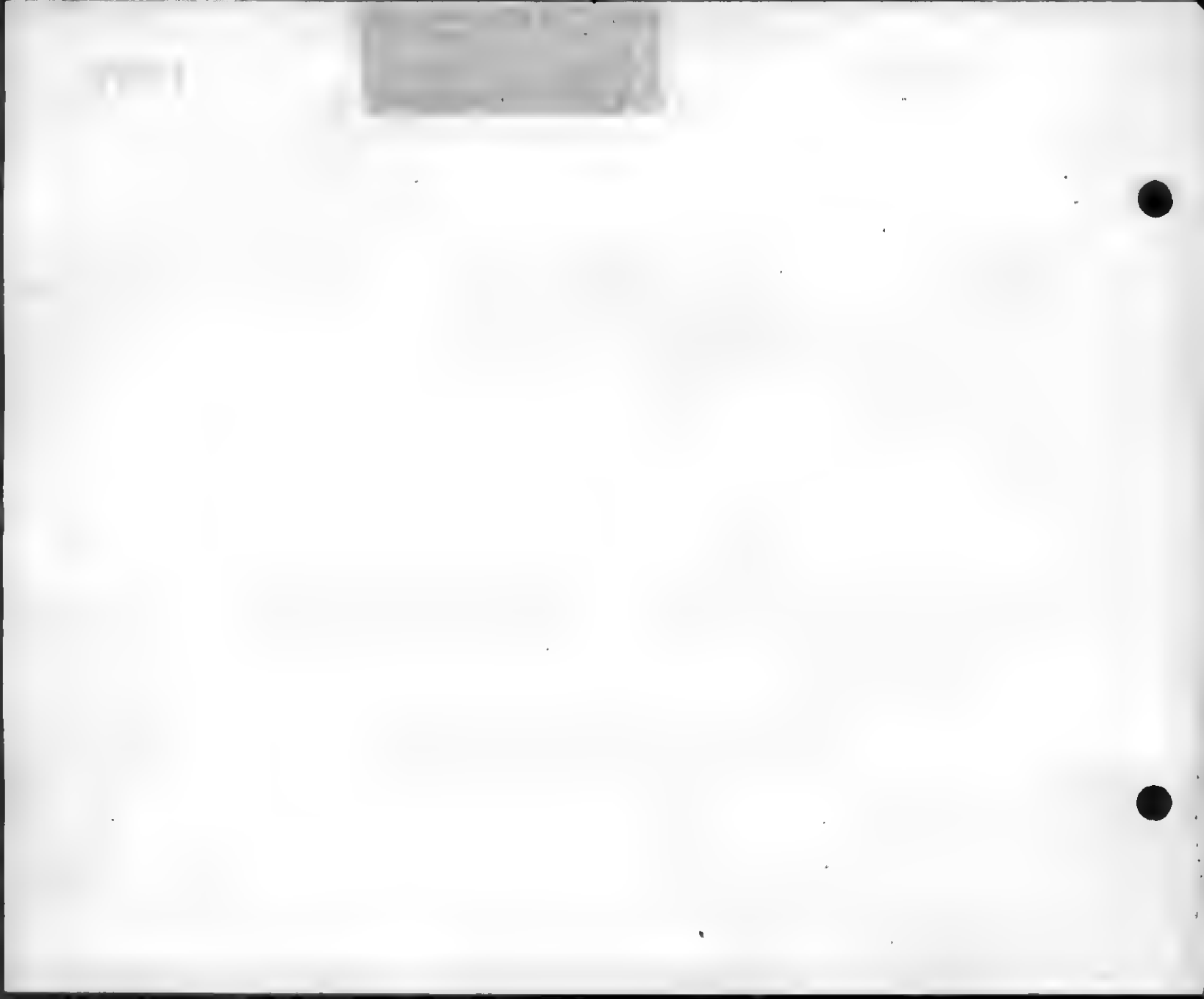
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15322

CERTIFICATE OF DEATH

15321

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 7b <b>2 wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>			d. STREET ADDRESS <b>3172 Remington Ave. 21211</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Wilbur E. LONGLEY</b>			4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1966</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1899</b>	9. AGE (In years last birthday) yrs <b>67</b>	10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insultman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balti. Transit Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ind.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Longley</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.I.</b>		
16. SOCIAL SECURITY NO. <b>213-10-2708A</b>			17. INFORMANT <b>William Longley - 3172 Remington Ave (11)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Tracheal obstruction by foreign body.</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subintimal hemorrhage right coronary artery.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>October 31, 1966</b> , to <b>November 15, 1966</b> that <b>he</b> (we) last saw the deceased alive on <b>November 15, 1966</b> , and that death occurred at <b>2:25 M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>M.S. Cockburn M.D.</b>			22b. DATE SIGNED <b>11/15/66</b>		22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/18/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) <b>Baltimore, Ind.</b>	(County) (State)	
24. FUNERAL DIRECTOR <b>John J. Cowan &amp; Son, Inc. 901 Hollins St.</b>		25a. REC'D BY REGISTRAR <b>23. MC.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>NOV 16 1966</b>					



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15323

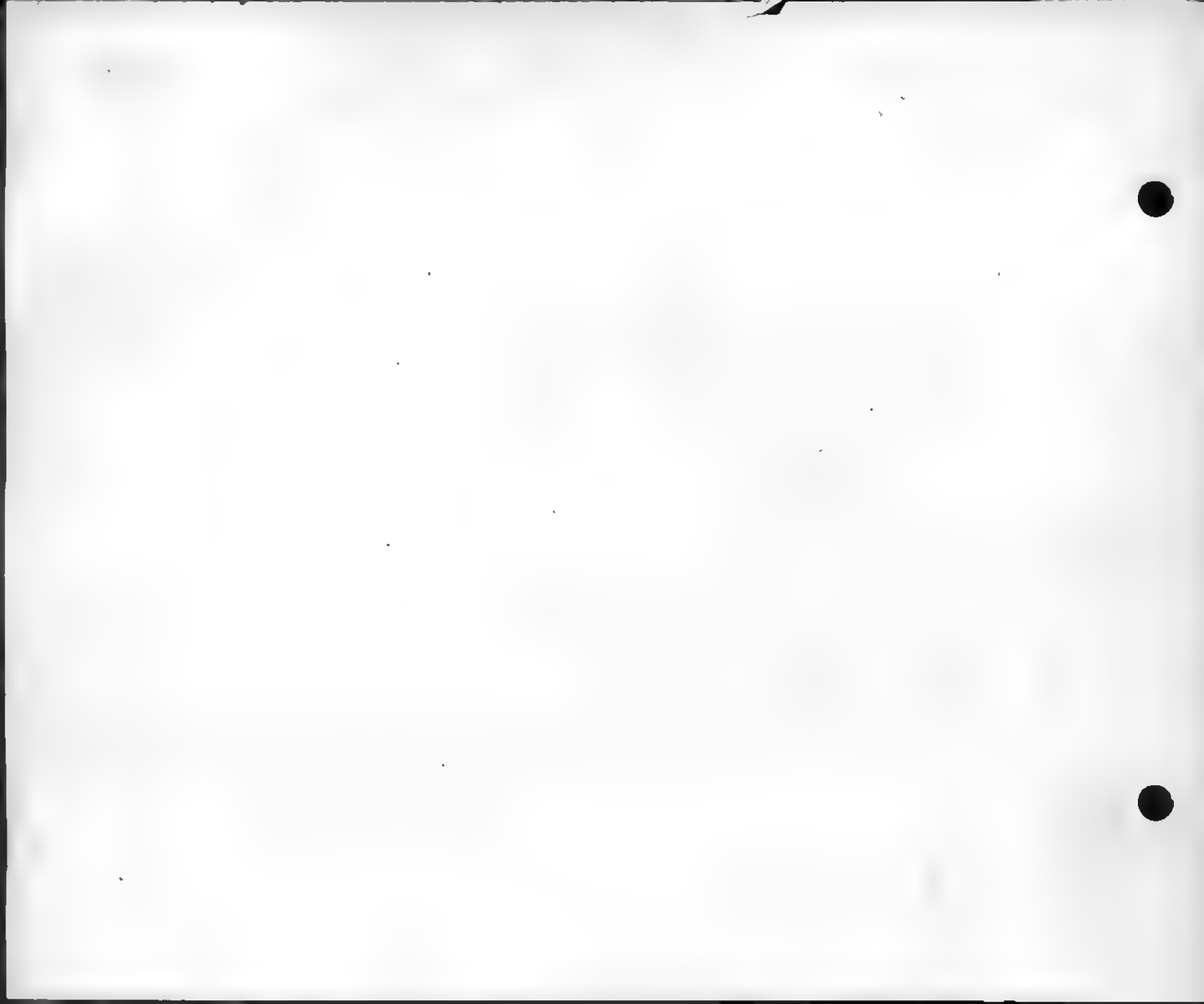
**CERTIFICATE OF DEATH**

15322

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c LENGTH OF STAY IN 1b <u>4 mos 16 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>Dogwood Rd.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Charles I. Lorentson, Sr.</u>				4 DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1966</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-18-87</u>	9. AGE (In years last birthday) <u>78</u> yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unempl.</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>CHARLES Lorentson</u>				14 MOTHER'S MAIDEN NAME <u>ANNA MARIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>470A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart failure.</u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> , 19 <u>66</u> to <u>11-13</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-13</u> , 19 <u>66</u> , and that death occurred at <u>7:10</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Narciso W. Carmina M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>11-13-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>NARCISO W. CARMINA</u>		22d. ADDRESS <u>Spring Grove State Hosp.</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		23b. DATE THEREOF <u>11/17/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berlin Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Berlin, New Jersey</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tubman &amp; Son</u>				ADDRESS <u>1011 York Mt. Rd. N. Baltimore</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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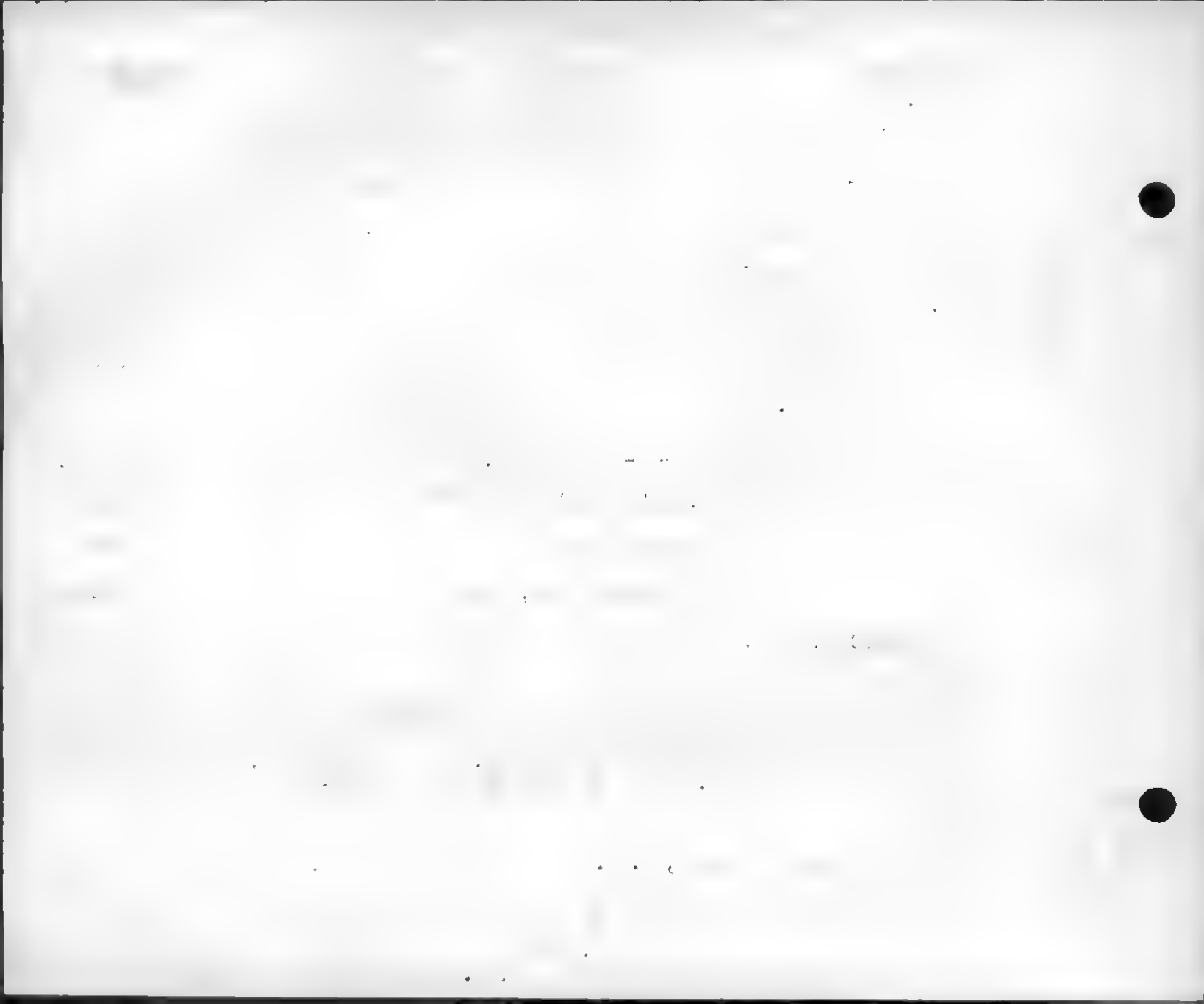
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15324

CERTIFICATE OF DEATH

15323

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1712 S. Hanover Street</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES EDWARD MARSH</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 8TH 19 66</b>	
5 SEX <b>Male</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1/22/18</b>
9. AGE (n years last birthday) <b>48 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orderly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>George F. Marsh</b>		14. MOTHER'S MAIDEN NAME <b>Mary Simmons</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>215-10-94-64</b>	
17. INFORMANT <b>Clin. Records, VA HOSPITAL, FORT HOWARD, MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY INFARCTION, RIGHT</b> <b>463X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY EMBOLI</b> DUE TO (c) <b>THROMBOPHLEBITIS, LEGS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>DAYS</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Nov. 3</b> , 1966, to <b>Nov. 8</b> , 1966, that (1) (we) last saw the deceased alive on <b>Nov. 8</b> , 1966, and that death occurred at <b>4:55A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Neilon Neilson, M.D.</i>		22b. DATE SIGNED <b>11/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/10/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>JAMES M. MC CULLY FUNERAL HOME, Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

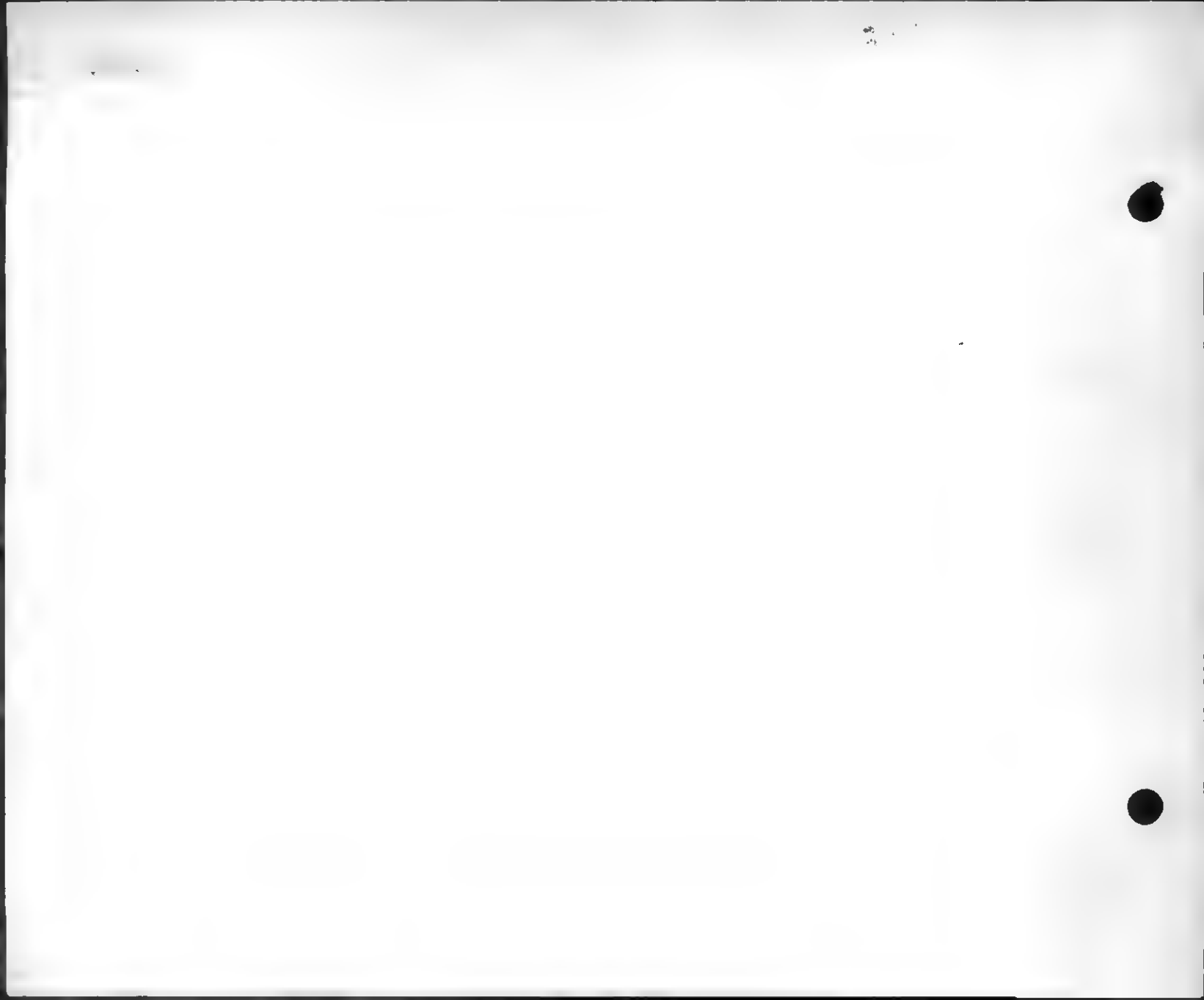
CERTIFICATE OF DEATH

15324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health.

1. NAME OF DECEASED (Type or print) <b>15325 Paulina H. Martin</b>		2. DATE AND HOUR OF DEATH <b>11-24-1966</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b> <b>BALTIMORE COUNTY</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE 6</b> <b>6014 Jaybreak Terrace</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTIMORE</b>	
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>2-23-1905</b> 9. AGE (in years last birthday) <b>71</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Alan Martin</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnathan</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-37200</b>	
17. INFORMANT <b>Mr. George H. Martin</b>		ADDRESS <b>6014 Jaybreak Terrace</b>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES <b>175.</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>carcinoma of ovary &amp; generalized metastases</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE			
22. I certify that (I) (this hospital) attended the deceased from <b>1-11-1952</b> to <b>Nov 24 1966</b> and that (I) (we) last saw the deceased alive on <b>Nov 24 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>B. V. Lockwood</b>		23B. DATE SIGNED <b>11/26/66</b>	
23C. PHYSICIAN'S NAME (Type) <b>BURTON V. LOCKWOOD</b>		23D. ADDRESS <b>2936 E. Pringle St Baltimore 21224</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-28-1966</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1966</b>		25C. FUNERAL DIRECTOR <b>Charles Judge</b>	
25B. NAME OF REGISTRAR <b>Charles Judge</b>		ADDRESS <b>1400 E. Federal Home Rd. Baltimore</b>	



CERTIFICATE OF DEATH

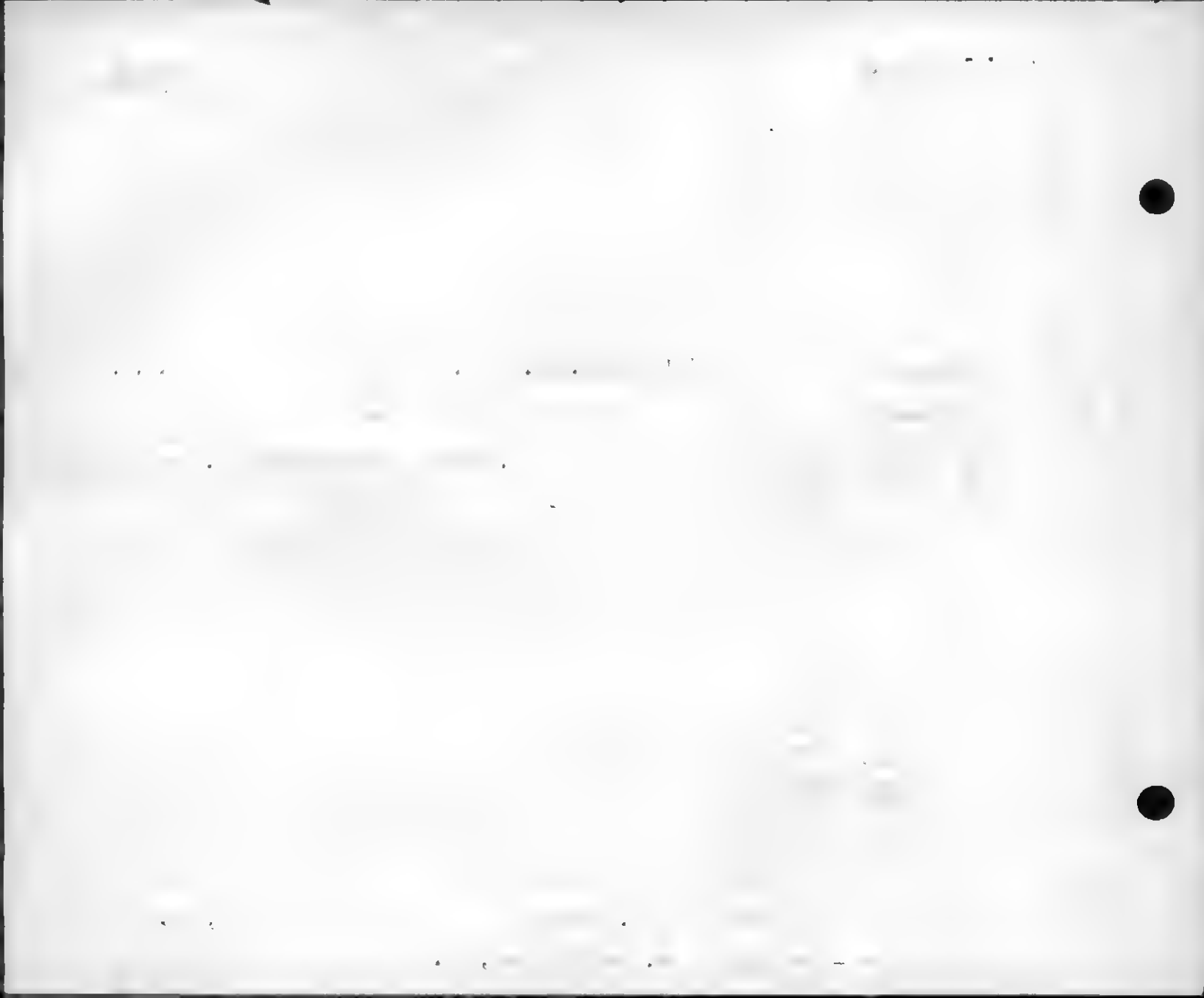
15326

15325

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN 1b <u>Randallstown</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>Box 220 Liberty Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Thelma</u> First Middle Last		4 DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-26-30</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reid's Const. Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Naomi Wheat</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-6981</u>	
17. INFORMANT <u>Mr. Vernon Wheat</u>		Address <u>Liberty Rd. Box 220</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Bilateral Bronchopneumonia</u> DUE TO (c) <u>2 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Kypho Scoliosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/25/66</u> , to <u>11/17/66</u> , that (I) (we) last saw the deceased alive on <u>11/17/66</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>M. J. Ellison</u>		22b. DATE SIGNED <u>11/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. J. Ellison</u>		22d. ADDRESS <u>8629 Liberty Rd - Randallstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	23d. LOCATION (City or Town) (County) (State) <u>Randallstown, Md.</u>
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 22 1966</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**15327**

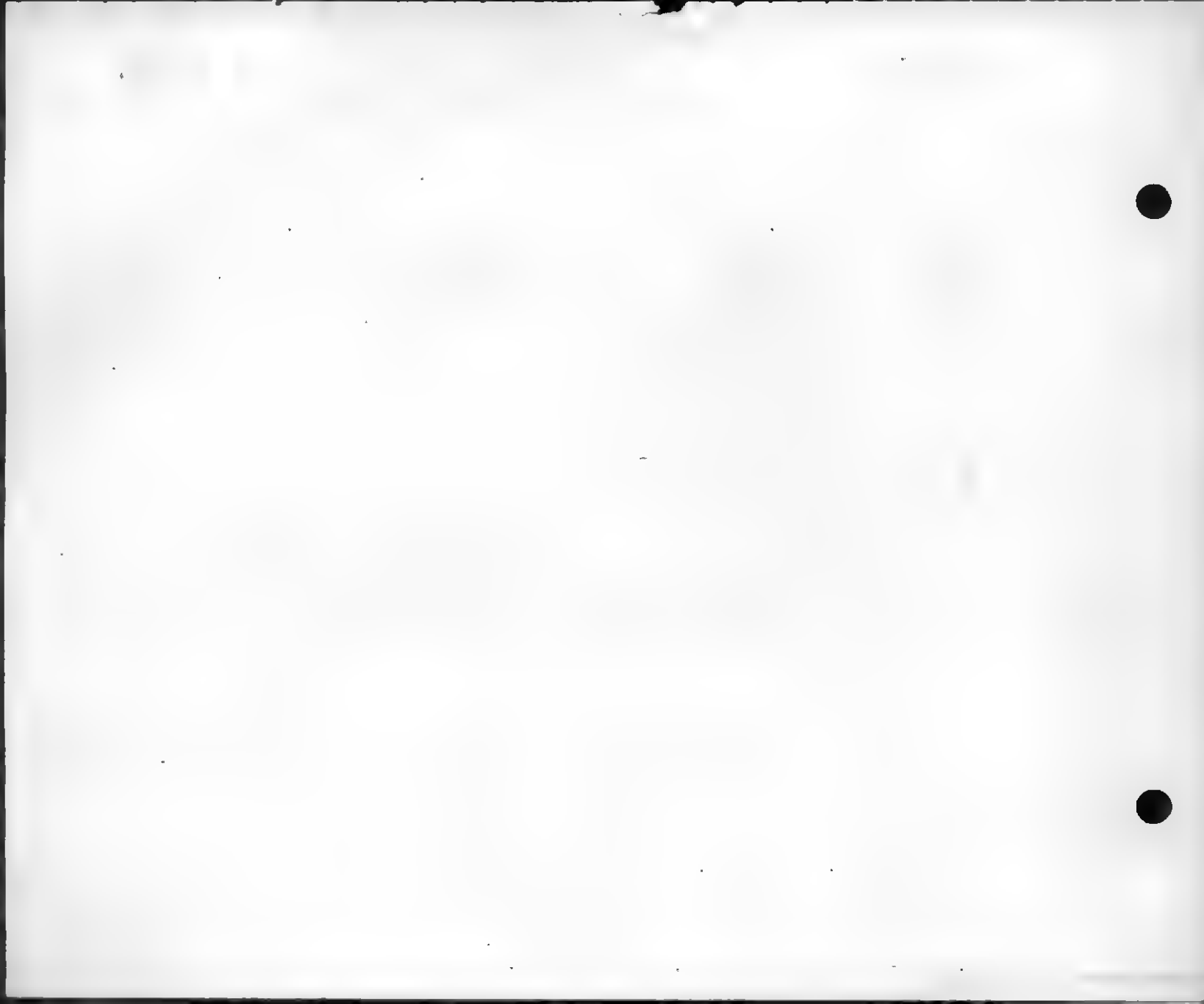
**CERTIFICATE OF DEATH**

**15326**

<b>1 PLACE OF DEATH</b> a COUNTY <b>Baltimore</b> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> c LENGTH OF STAY in ib <b>20 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Northwood Rd.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> d STREET ADDRESS <b>5 Northwood Rd.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <b>Alethia Gladys Mather</b>				<b>4 DATE OF DEATH</b> Month Day Year <b>Nov. 26 19 66</b>													
<b>5 SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <b>1899</b> <b>Jan. 18, 1899</b>		<b>9 AGE (n years lost birthday)</b> <b>68 67 yrs</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS</b> Hours Min.					
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>clerk</b>				<b>10b KIND OF BUSINESS OR INDUSTRY</b> <b>Restaurant</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore County, Md.</b>				<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>William Craumer</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Alica Hedrick</b>											
<b>15 WAS DECEASED EVER IN U S ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				<b>16 SOCIAL SECURITY NO.</b> <b>21340 -0110</b>				<b>17. INFORMANT</b> Address									
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PHLEGMASIA CEREBRA DOLENS</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 mos</b> <b>5 yrs</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>April</b> , 1966, to <b>Nov. 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 25</b> , 1966, and that death occurred at <b>7 A.</b> M, from causes and on the date stated above.																	
<b>22a SIGNATURE</b> <b>William A. Pillsbury</b>						<b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> M.D.				<b>22b DATE SIGNED</b> <b>11-28-66</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. William A. Pillsbury</b>						<b>22d. ADDRESS</b> <b>2060 York Rd. Timonium, Md.</b>											
<b>23a BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>11-28-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Poplar Grove Cemetery</b>				<b>23d LOCATION (City or Town)</b> (County) (State) <b>Cockeysville Maryland</b>							
<b>24. FUNERAL DIRECTOR</b> <b>Wm. Cook-Brooks Towson Inc.</b>						<b>10905 York Rd. Towson, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 1 1966</b>				<b>25b REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

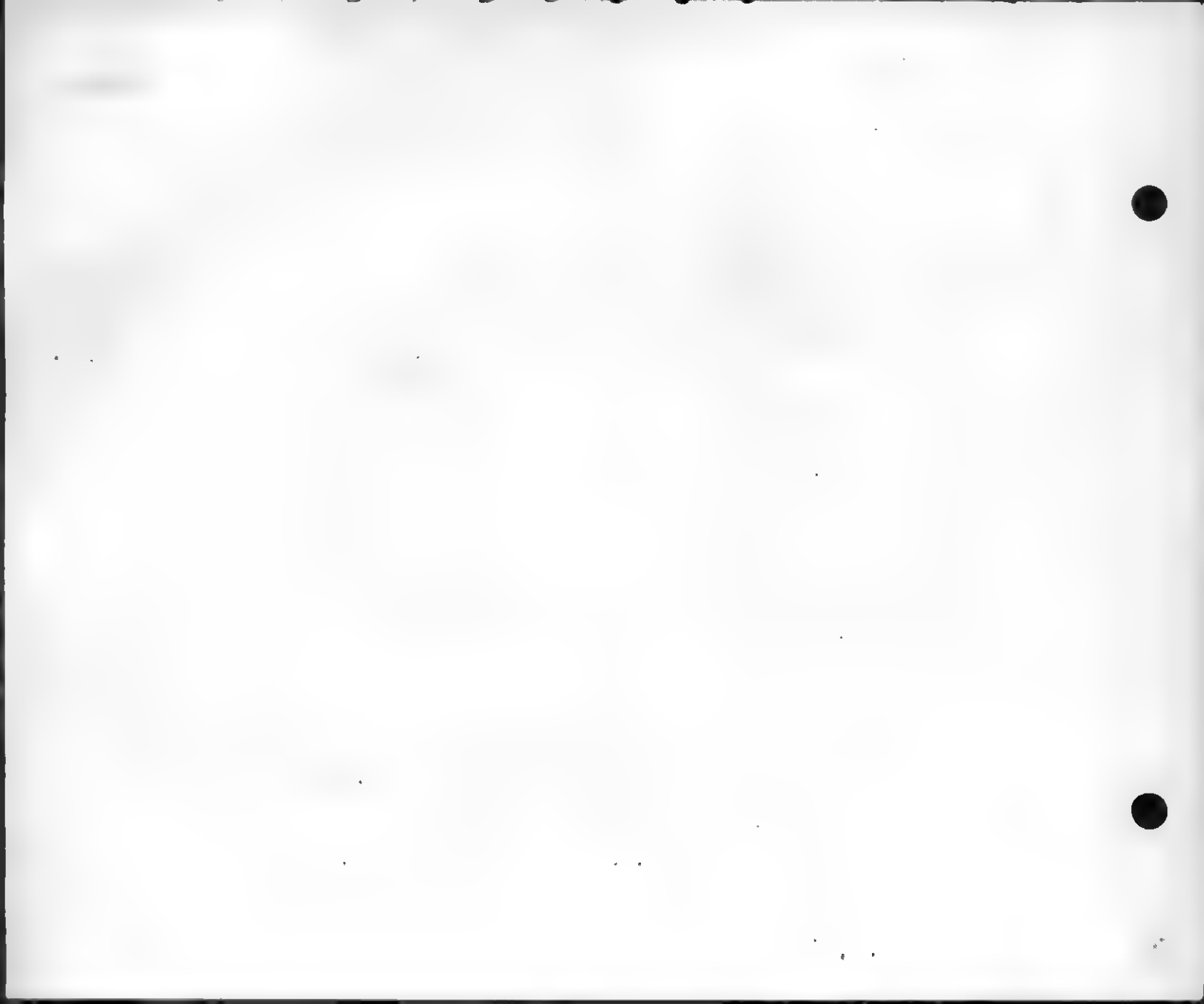
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15328 CERTIFICATE OF DEATH 15327											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>3 1/2 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>7206 Forest Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Philip</b> Last <b>MATTHEWS</b>				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>19 66</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-18-59</b>		9. AGE (In years last birthday) <b>7</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pittsburg, Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Thomas Tucker</b>				14. MOTHER'S MAIDEN NAME <b>Lois Jean Matthews</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration</b> DUE TO <b>Diarrhea</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe hydrocephalus</b> INTERVAL BETWEEN ONSET AND DEATH <b>3d</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-6</b> , 19 <b>62</b> , to <b>11-14</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11-14</b> , 19 <b>66</b> , and that death occurred at <b>11:30</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Zsolt Koppanyi</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>11/14/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Zsolt Koppanyi, M.D.</b>				22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood</b>		23d. LOCATION (City, town or county) (State) <b>Owings Mills Md.</b>			
24. FUNERAL DIRECTOR <b>J.F. Elmer &amp; Sons</b>				ADDRESS <b>Reisterstown Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



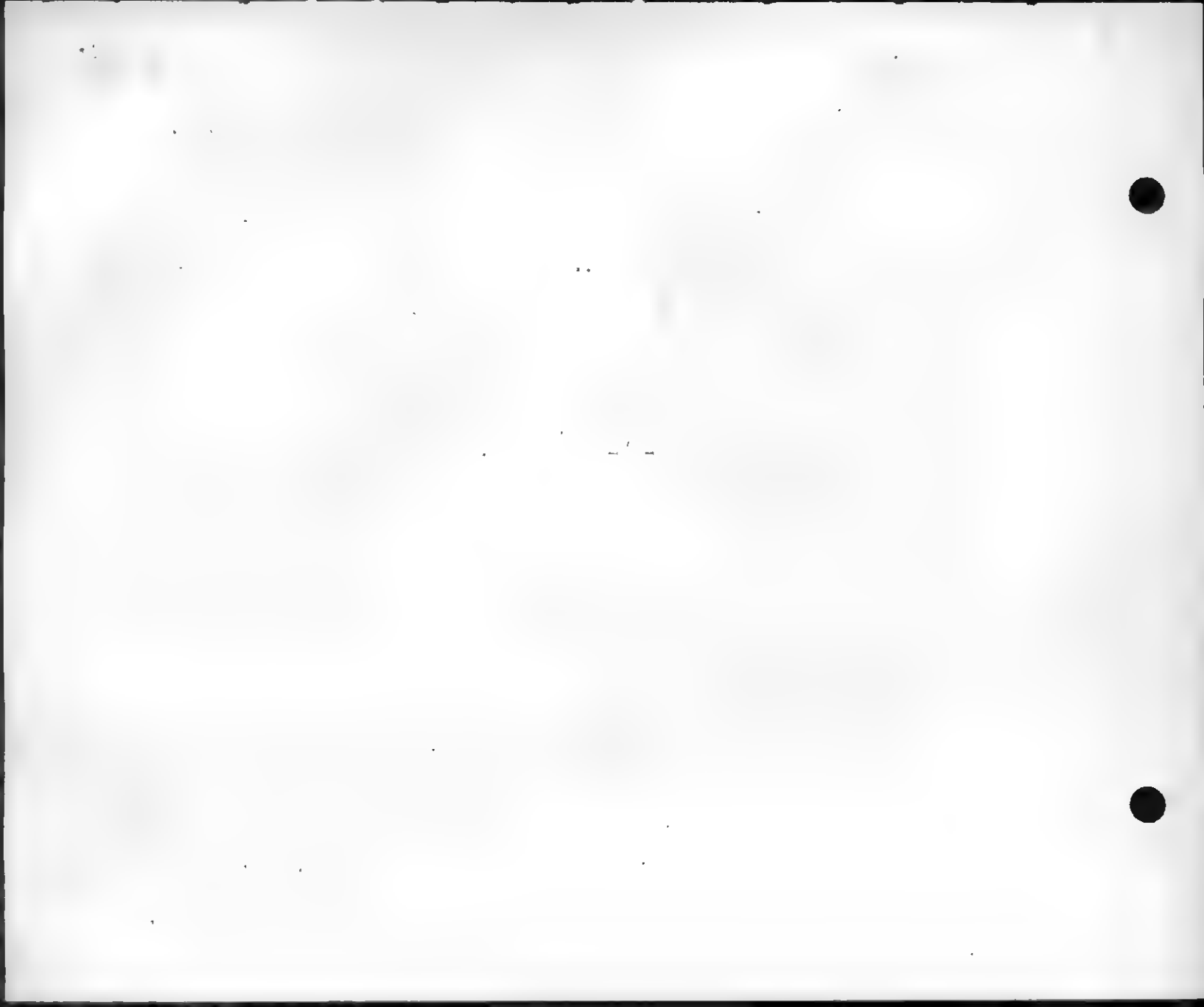


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15329 CERTIFICATE OF DEATH 15328

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN IL <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House in the Pines - Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>Route 6 Box 282</b> e. IS RESIDENCE ON A FARM? <b>21122</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>L.</b> Last <b>May</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>63</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Hill McCabe</b>		14. MOTHER'S MAIDEN NAME <b>Effie May Helsby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-5399</b>	
17. INFORMANT <b>Mrs. Alice Glasgow</b>		Address <b>same address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>10-18</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pancreatic Colon.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>137</b> <b>330</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-26, 1966</b> , to <b>11-5, 1966</b> , that (I) (we) last saw the deceased alive on <b>11-28-1966</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wilmer K. Gallagher</b>		22b. DATE SIGNED <b>11-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		22d. ADDRESS <b>6209 Frederick Ave. Balt. 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. F. Tibbitt Sons</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 9 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

15330

MARYLAND STATE DEPARTMENT OF HEALTH

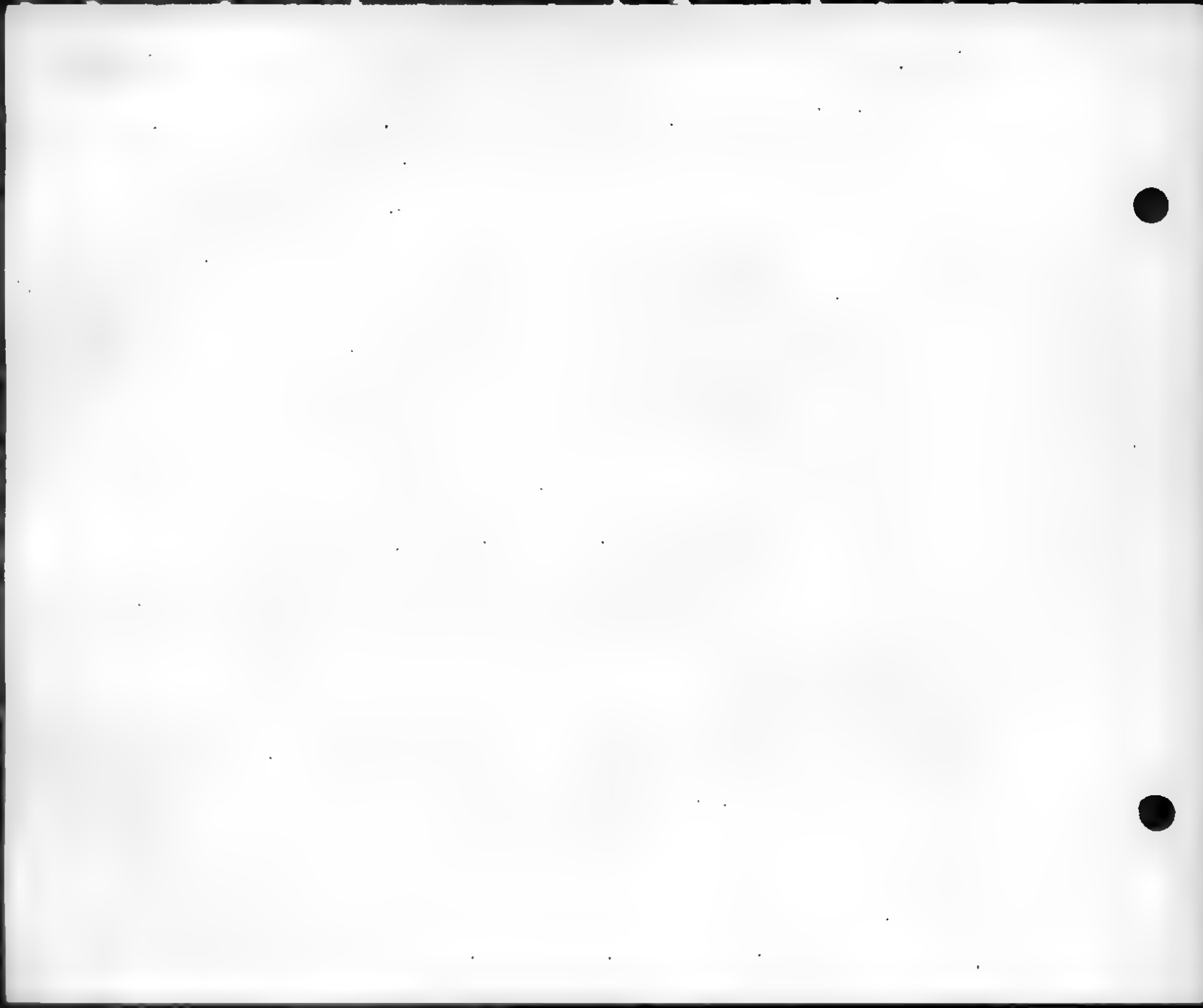
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15329

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>GREATER BALT MED CENTER</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN ID <u>1 month 27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AS ABOVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALT.</u> d. STREET ADDRESS <u>1541 Wilkman Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First <u>Nestor</u> Middle <u>McGOWAN</u> Last			4. DATE OF DEATH <u>NOV.</u> Month <u>17</u> Day <u>1966</u> Year				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Can</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3/20/18</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALT. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Eugene McGOWAN</u>		14. MOTHER'S MAIDEN NAME <u>Bunker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Lt Col</u>		16. SOCIAL SECURITY NO. <u>217-03-7829</u>		17. INFORMANT <u>WIFE</u> Address <u>ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE</u> DUE TO (b) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>66</u> , to <u>11/17</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>17</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/17/66</u>		22c. PHYSICIAN'S NAME (Type) <u>LARRY CHONG</u>			
22d. ADDRESS <u>GREATER BALT MED Center</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mon. 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt. Alirex</u>			
23d. LOCATION (City, town or county) <u>Balto. Md.</u>		23e. (State)					
24. FUNERAL DIRECTOR <u>John W Connelly Sons</u>		ADDRESS <u>300 Mac Ave, 21</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. DATE					

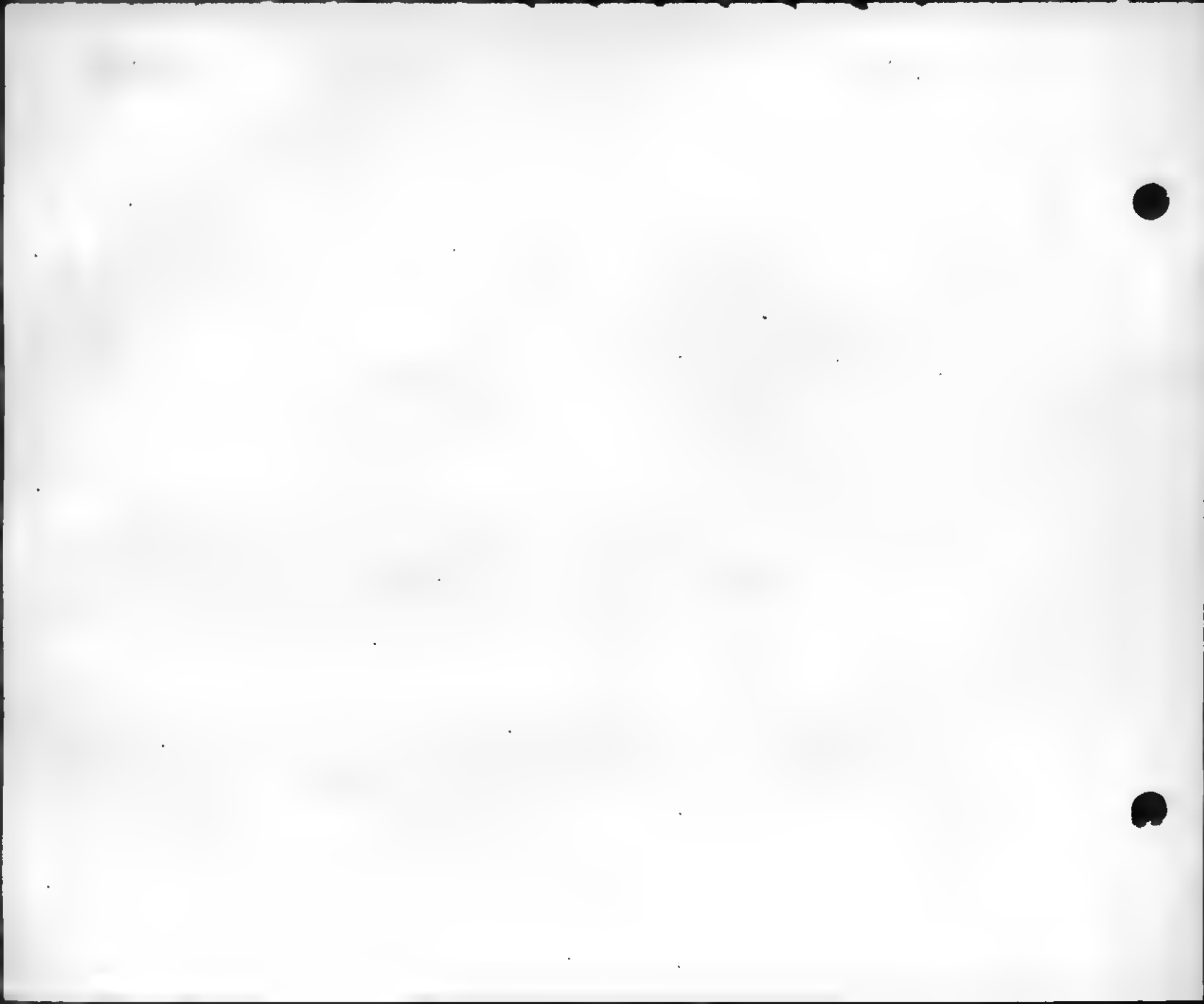
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15331											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>9 weeks</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shangri-La Nursing</u>				d. STREET ADDRESS <u>1819 Sulphur Spring Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>EDGAR</u> Last <u>MELVIN</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/21/97</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min. <u>1966</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Building</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Melvin</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Yeager</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>212-09503</u>				17. INFORMANT <u>Jean Burke</u> Address <u>5518 Linix Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1767</u> <u>osteogenic sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>_____</u> DUE TO (c) <u>_____</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>_____</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>1966</u> <u>2 yrs -</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u>_____</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept - 1966</u> to <u>Nov 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 12, 1966</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Earl Pass</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11-14-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>I EARL PASS MD</u>				22d. ADDRESS <u>4001 Wickers Ave Baltimore</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Arthur Fox</u>				ADDRESS <u>1328 Sulphur Sp. Rd.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 17 1966</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15332

CERTIFICATE OF DEATH

15331

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> <u>13.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 WARREN RD</u>			d. STREET ADDRESS <u>7 WARREN RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First <u>A.</u> Middle <u>MESSENGER</u> Last			4. DATE OF DEATH Month <u>NOV.</u> Day <u>30</u> Year <u>1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/27/1888</u>	9. AGE (In years lost birthday) <u>78</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JOHN MESSENGER</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH RIDER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MAMIE MESSENGER</u> Address <u>7 WARREN RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF KIDNEY WITH</u> <u>180X</u> DUE TO (b) <u>METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MARGINAL ULCER SITE OF GASTROENTEROSTOMY</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 16</u> , 19 <u>66</u> , to <u>NOV. 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV. 27</u> , 19 <u>66</u> , and that death occurred at <u>4:45 PM</u> , from causes on and on the date stated above.					
22a. SIGNATURE <u>Joseph Miceli</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI, MD.</u>		22d. ADDRESS <u>108 S TAYLOR AVE</u> <u>ESSEX, MD</u> <u>21221</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PAK LAWA</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR <u>Connelly Inc</u>		ADDRESS <u>300 Imace</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 5</u> 19 <u>66</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

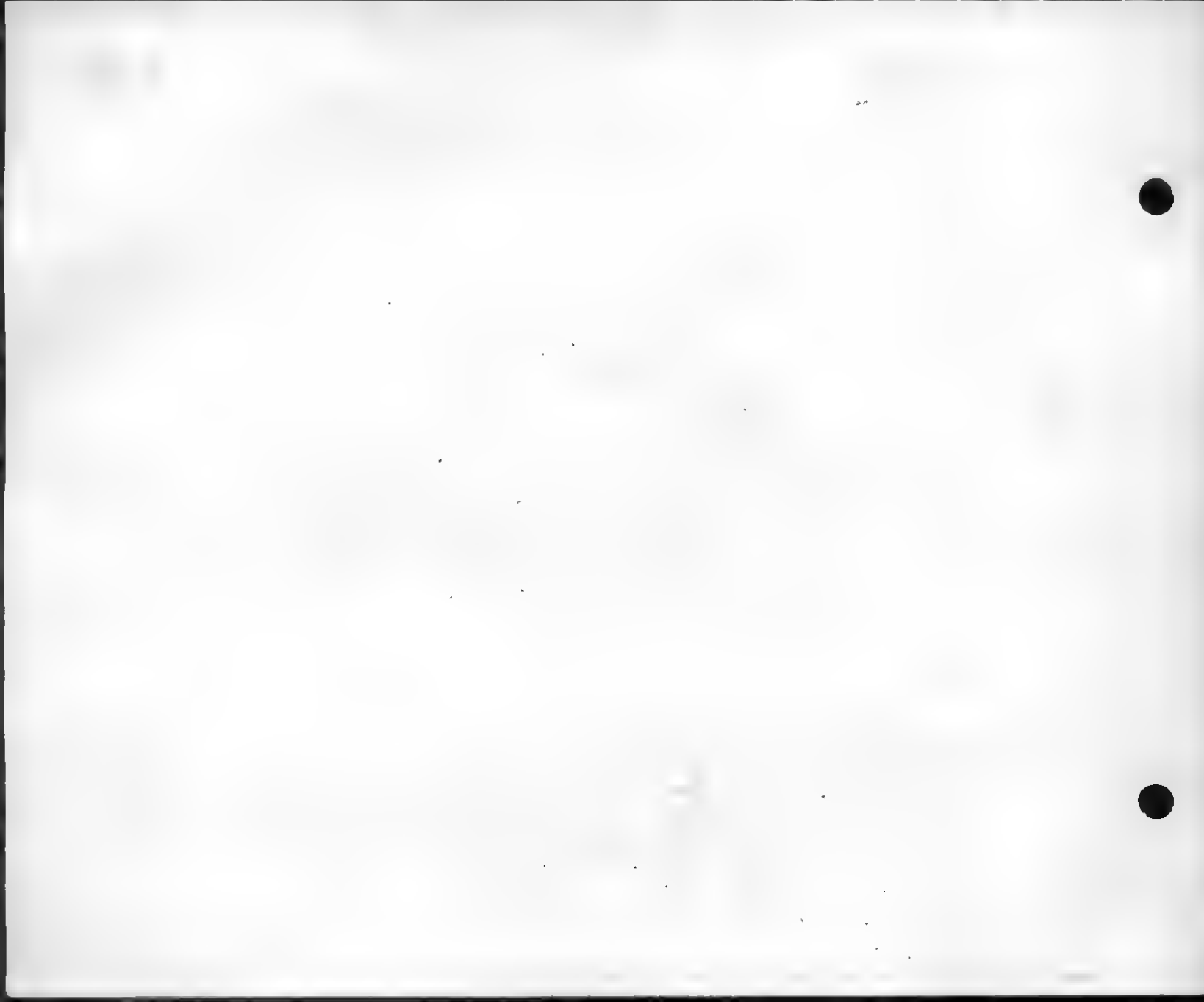
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15333

CERTIFICATE OF DEATH

15332

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>21234</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>8125 Hillendale Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>P. PAUL</b> Last <b>Mettee</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 25-1906</b>	
9. AGE (In years last birthday) <b>59</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIRE FIGHTER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO., MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN METTEE</b>				14. MOTHER'S MAIDEN NAME <b>IDA HENCK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>219-225177</b>		17. INFORMANT <b>WIFE</b> Address <b>MRS. FLORENCE B. METTEE (SAME)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive gastrointestinal hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>intra - duodenal perforation of aortic aneurysm.</b> DUE TO (c) <b>Aortic arteriosclerosis.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>14</b> (this hospital) attended the deceased from <b>11/7/</b> , 19 <b>66</b> to <b>11/7/</b> , 19 <b>66</b> , that <b>14</b> (we) last saw the deceased alive on <b>11/7/</b> , 19 <b>66</b> , and that death occurred at <b>9:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-11-1966</b>		23c. NAME OF CEMETERY <b>MORELAND MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>TAYLOR AVE BALTO., MD</b>	
24. FUNERAL DIRECTOR <b>J. Walter Conklin</b>				ADDRESS <b>5444 BELAIR Rd.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

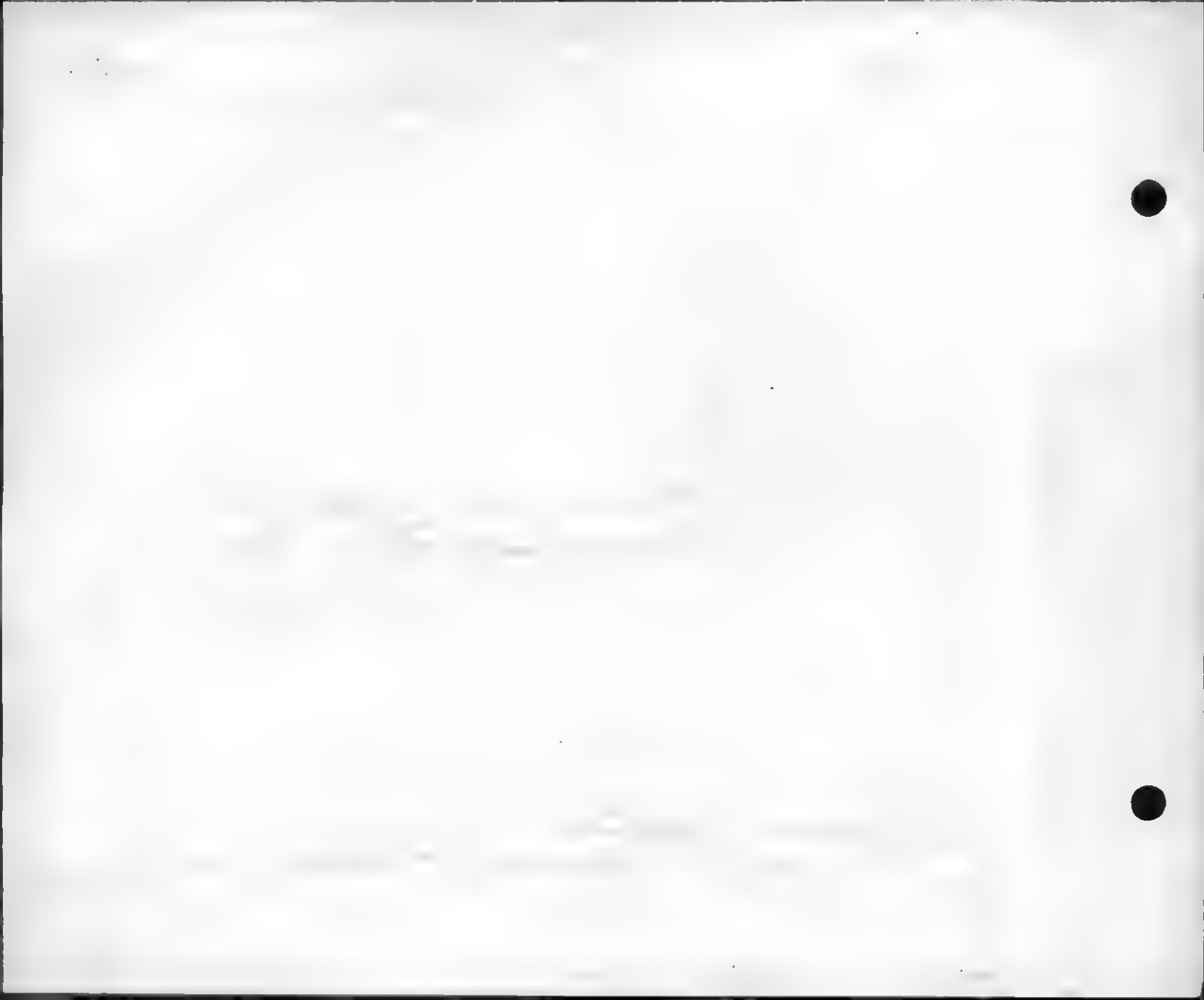
MD. STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

153334

CERTIFICATE OF DEATH

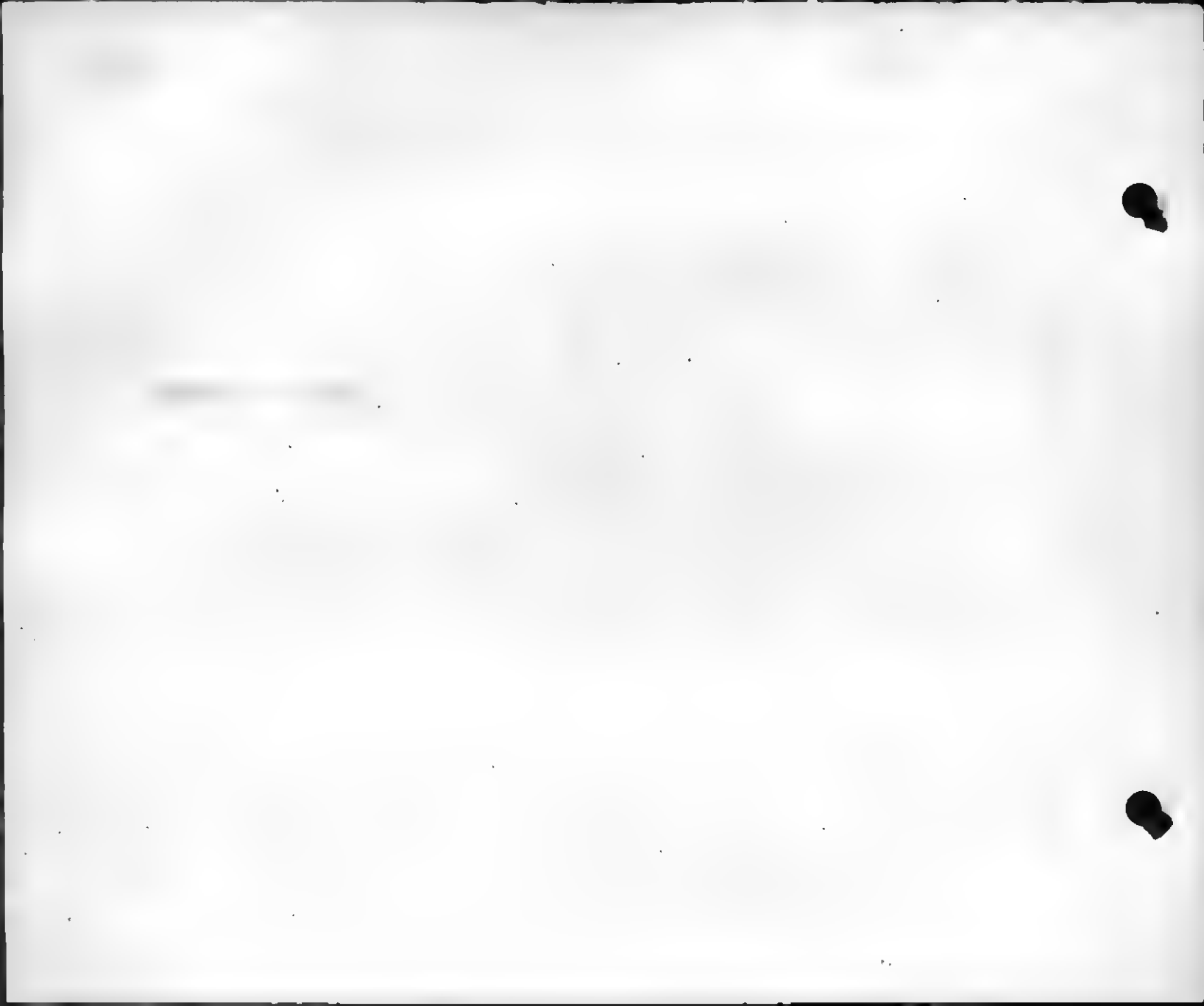
153333

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3143 Yorkway Dundalk</u>		d. STREET ADDRESS <u>3010 Lavender Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>D</u> Last <u>Meyers</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, event if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Turner</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Allan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Anna Peck</u>		Address <u>3143 Yorkway Dundalk</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-Vasc. Accident (stroke)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerotic C.D.</u> (c) <u>10/31/66</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1966-10-31</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> , 19 <u>66</u> , to <u>11-1</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-1</u> , 19 <u>66</u> , and that death occurred at <u>7</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel J. Harkin</u> M.D.		22b. DATE SIGNED <u>11-2-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL J. HARKIN</u>		22d. ADDRESS <u>3479 LIBERTY PIKE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore MD</u>	
24. FUNERAL DIRECTOR <u>Lorraine Fann/Horn</u>		25a. REC'D BY REGISTRAR <u>7401 Belair Rd.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 4 1966</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER Baltimore Medical Center</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>21236</u> d. STREET ADDRESS <u>4313 Fitch Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>FREDERICK</u> Last <u>Michel</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>12</u> Year <u>1966</u>				<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9/8/83</u> <b>9. AGE</b> (In years last birthday) <u>83</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Mins. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Florist</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Business</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>HENRY Michel</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Eberhardt</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>213-36-5427T</u> <b>17. INFORMANT</b> <u>Hospital Chart</u> Address <u>  </u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Pneumonia - pneumonia -</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Congestive heart failure</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town) (County) (State)</b> <u>  </u> <u>  </u> <u>  </u>				<b>21. I certify that</b> <u>  </u> (this hospital) attended the deceased from <u>9/11/66</u> , 19 <u>66</u> , to <u>12/11/66</u> , 19 <u>66</u> , that <u>  </u> (we) last saw the deceased alive on <u>12/11/66</u> , 19 <u>66</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>T. J. C. Cullis M.D.</u> <b>22b. DATE SIGNED</b> <u>12 Nov 66</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>T. C. Cullis M.D.</u> <b>22d. ADDRESS</b> <u>Greater Baltimore Medical Center</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>11-16-1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore</u> <u>  </u>				<b>24. FUNERAL DIRECTOR</b> <u>Lassahn Funeral Home</u> <u>7401 Belden Road</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>NOV 16 1966</u>							



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 15ME (5)  
6M 1/66

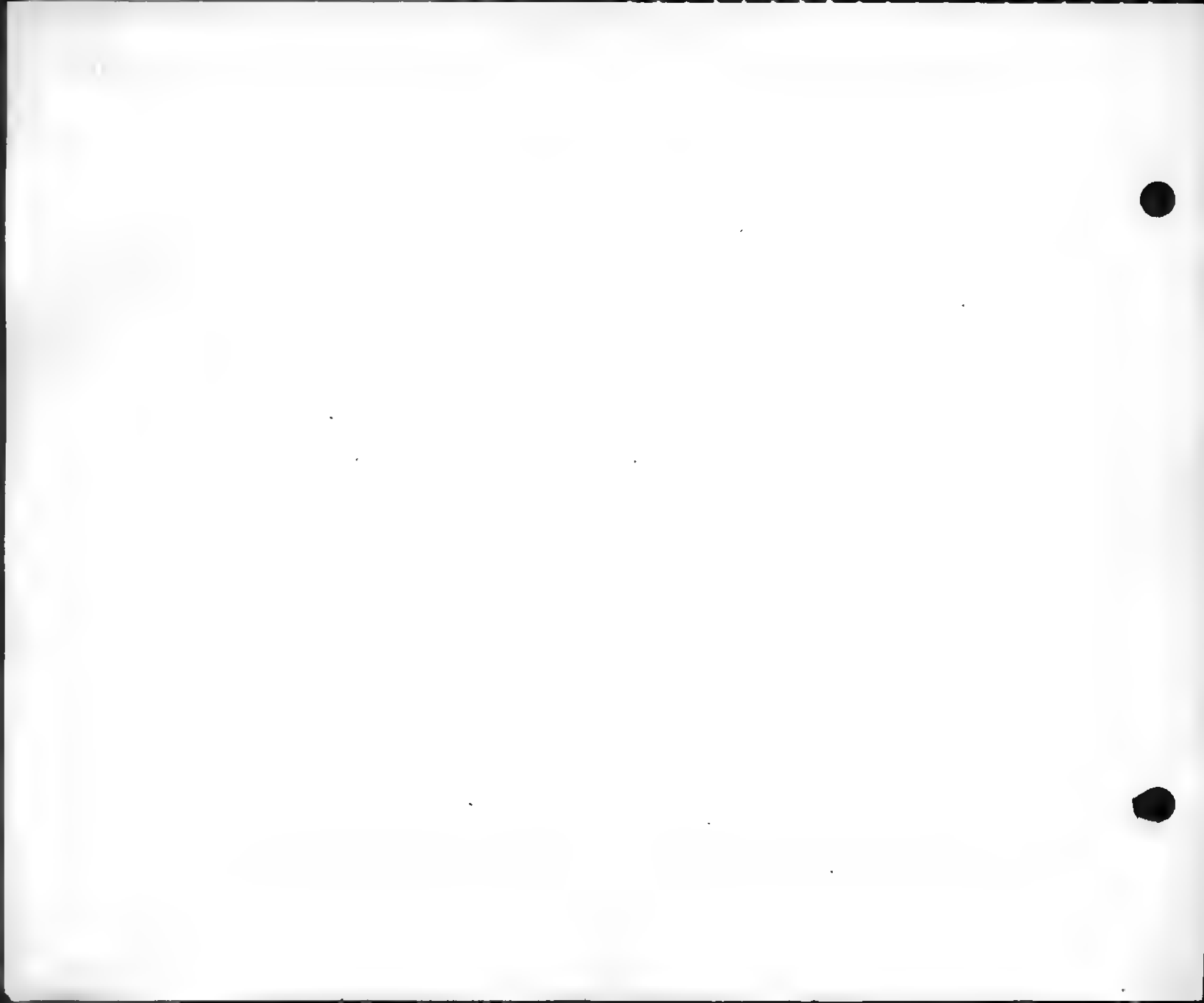
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**15336**

**15335**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>		c. LENGTH OF STAY IN Id	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1629 W. Joppa Road</b>		d. STREET ADDRESS <b>1629 W. Joppa Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Edward Miller</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1896</b>
9. AGE (in years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co., Metro.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Miller</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>214-16-8309</b>	
17. INFORMANT <b>Family Records</b>		Address	
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Chronic Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>10 yrs</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>11/14/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 16, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Saters Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lutherville, Md.</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

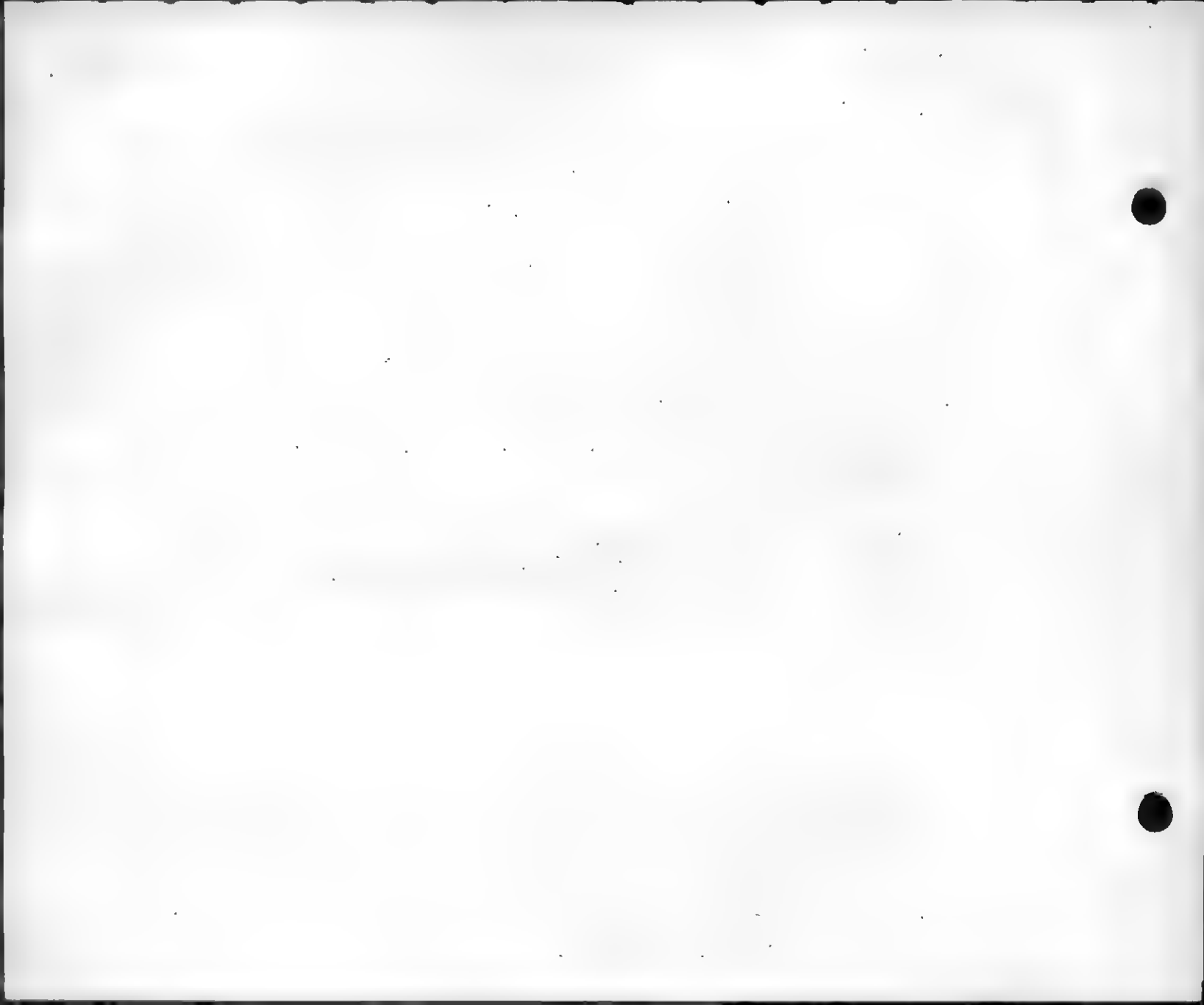
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15337 CERTIFICATE OF DEATH 15336

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>10 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Med. Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MICH</u> b. COUNTY <u>HUBBARD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HUBBARD</u> d. STREET ADDRESS <u>-</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Monticello</u> Last <u>Monticello</u>				4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/27/1900</u> 9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.A.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence Manzetti</u>				14. MOTHER'S MAIDEN NAME <u>Maria Manzetti-Rossio</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>378-30-3601</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO (b) <u><del>Metastatic carcinoma</del> DISSEMINATED</u> DUE TO (c) <u>MALIGNANT LYMPHOMA</u> underlying cause last. <u>Breast carcinoma of left breast?</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> , 19 <u>66</u> , to <u>11-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 10</u> , 19 <u>66</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Doris C Kuwilsky</u> 22c. PHYSICIAN'S NAME (Type) <u>Dora C Kuwilsky</u>				22b. DATE SIGNED <u>11-10-66</u> 22d. ADDRESS <u>Greater Baltimore Medical Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 14, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View</u>		23d. LOCATION (City, town or county) (State) <u>Calumet, Mich.</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>				25a. REC'D BY REGISTRAR <u>Nov 14 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

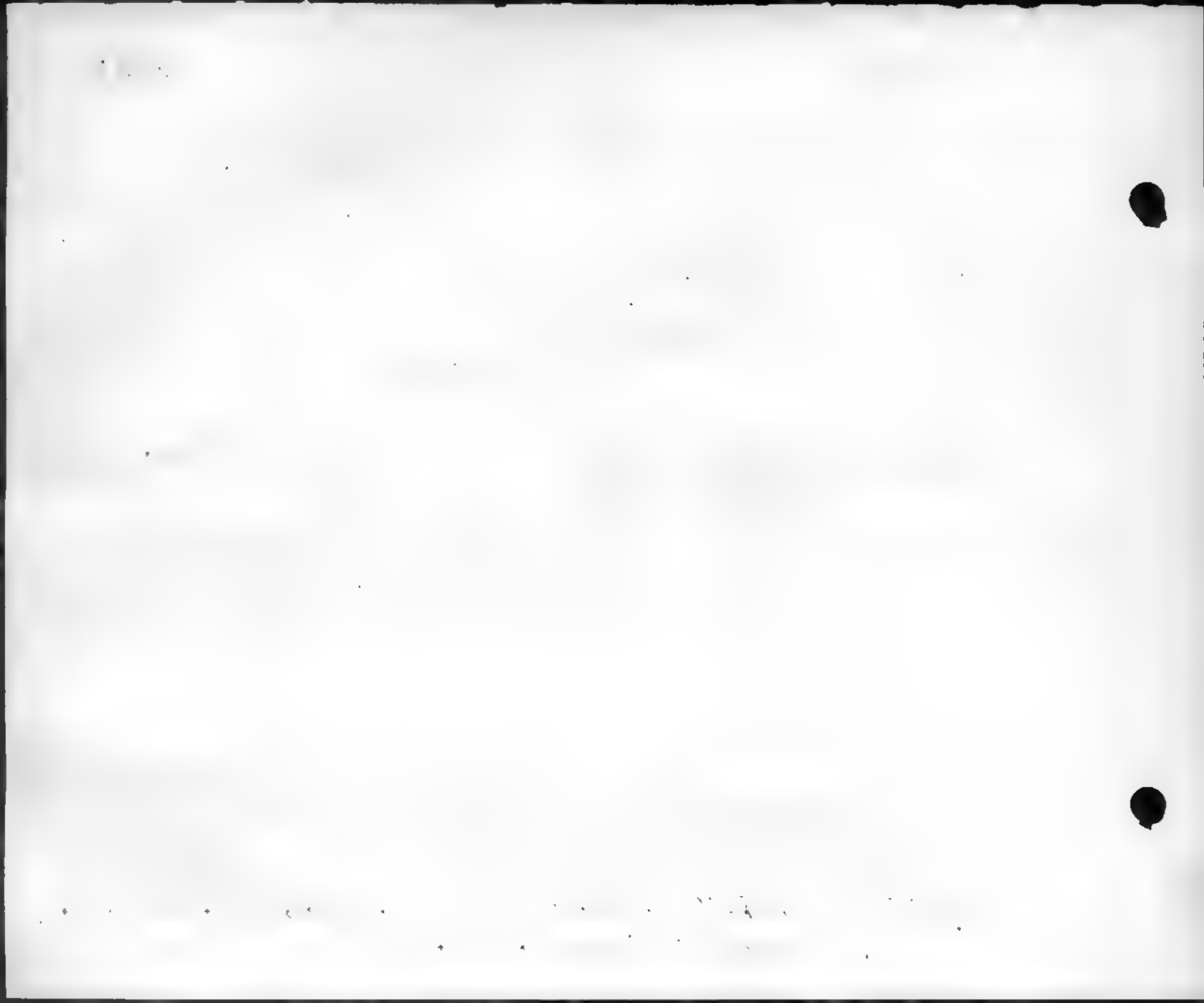
MEDICAL CERTIFICATION



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
15338						15337									
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			a. STATE			b. COUNTY			
Baltimore			Towson			MORGAN			Md.			Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. STREET ADDRESS						f. IS RESIDENCE ON A FARM?			
Greater Balto. Med. Center						512 Morris Ave.						YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
Baby Boy			Morgan						11			22 1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF FUNDER 1 YEAR		IF FUNDER 24 HRS.			
M		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-22-66		yrs.		Months		Days			
												Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
								Balto. Co. Md.							
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
James Morgan						Bernice Kenney									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT						Address			
						Mother's + Baby's chant (Hosp. Records)									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												2-4 hrs.			
1600 DUE TO Respiratory Distress															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO Resp. Distress Syndrome															
(c) Respirator pneumonia															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
21. I certify that (I) (this hospital) attended the deceased from 6:30 am 11/22, 1966, to 12 noon 11/22, 1966, that (I) (we) last saw the deceased alive on 11/22, 1966, and that death occurred at 12 noon from the causes and on the date stated above.															
22a. SIGNATURE												22b. DATE SIGNED			
[Signature]												11/22/66			
22c. PHYSICIAN'S NAME (Print)												22d. ADDRESS			
LOIS MARY ACHIMOVICH												GREATER BALTO. MED. CENTRE			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)					
Burial				11/23/1966		Ebenezer Methodist Cem.				Chase, Balto. County, Md.					
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
G. Vernon Lemmon 4611 Park Heights Ave. Balto.												NOV 25 1966		[Signature]	



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VR A15 (4)  
20 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15339

CERTIFICATE OF DEATH

15338

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>				c LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wiseburg Rd.</u>				d. STREET ADDRESS <u>Wiseburg Rd.</u>			
3 NAME OF DECEASED (Type or print) <u>FREDERICK M. MORT</u>				4 DATE OF DEATH <u>Nov 28</u> 19 <u>66</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 23/1895</u>	9. AGE (In years last birthday) <u>71</u> yrs	10 UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper.</u>		11 BIRTHPLACE (County & State or foreign country) <u>Winchester, Va</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Mort</u>				14. MOTHER'S MAIDEN NAME <u>Lelia M.</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-01-0179</u>		17. INFORMANT <u>Mrs. Marie Mort, White Hall, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>H. P. C. I. disease - Congestion / ischemia</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Em. Hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>66</u> , to <u>11/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>66</u> , and that death occurred at <u>2:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>H. H. France</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. H. FRANCE</u>				22d. ADDRESS <u>PARKTON Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>Nov. 30, 1966</u>		<u>Heretford Baptist Cem</u>		<u>Parkton Md.</u>	
24. FUNERAL DIRECTOR <u>Paul Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

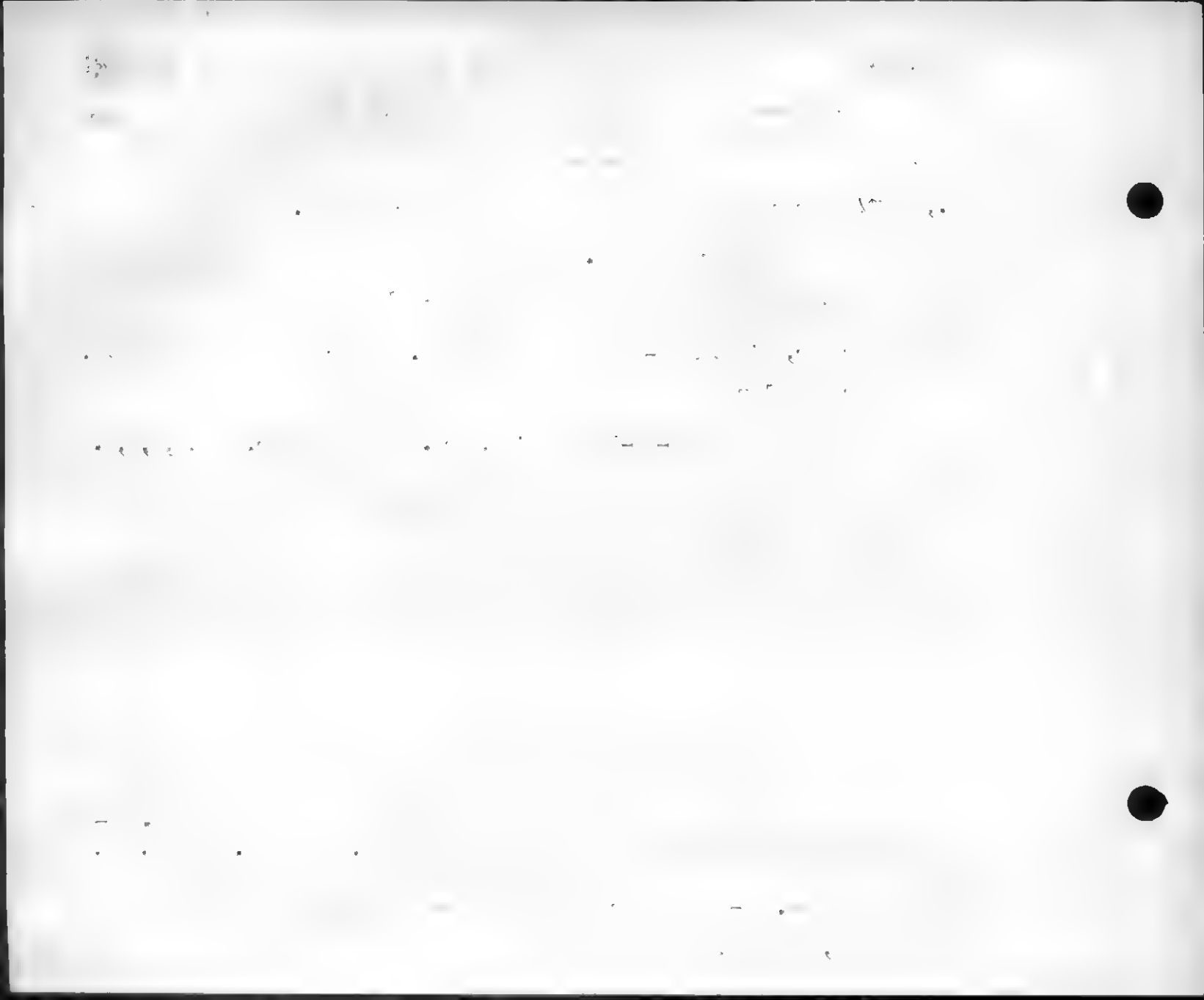


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VR A15 (4)  
15M 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>15340</b></p> </div> <div style="text-align: center;"> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>15339</b></p> </div> </div>									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Baltimore</b> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b></p> <p>c. LENGTH OF STAY IN 1b <b>17 years</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 8234 Cornwall Road</b></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> 03.1</p> <p>d. STREET ADDRESS <b>8234 Cornwall Rd. 21222</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) <b>Theodore H. Mueller</b></p>			<p>4. DATE OF DEATH <b>November 20-1966</b></p>						
<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>					
<p>8. DATE OF BIRTH <b>Oct. 23-1914</b></p>		<p>9. AGE (in years last birthday) <b>52</b> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ambulance Driver, Dispensary- Bethlehem Steel Co.</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b></p>					
<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>U.S.A.</b></p>				<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>					
<p>13. FATHER'S NAME <b>Henry Mueller</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Mary Dorsey</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>216-09-2094</b></p>		<p>17. INFORMANT <b>Wife, Mrs. Janet Mueller, # 2, a, b, c, d.</b></p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</p> <p>(b) <b>DUE TO</b></p> <p>(c) <b>DUE TO</b></p>					<p>INTERVAL BETWEEN ONSET AND DEATH</p>				
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>									
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>									
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year <b>19</b></p> <p>Hour a.m. p.m.</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>					
		<p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that (I) (this hospital) attended the deceased from <b>12/18</b>, 19<b>66</b>, to <b>Nov. 19</b>, 19<b>66</b>, that (I) (we) last saw the deceased alive on <b>11/19</b>, 19<b>66</b>, and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.</p>									
<p>22a. SIGNATURE <b>Zachariah Morgan</b></p>				<p>22b. DATE SIGNED <b>Nov. 21-1966</b></p>					
<p>22c. PHYSICIAN'S NAME (Type) <b>Zachariah Morgan</b></p>				<p>22d. ADDRESS <b>10 E. Eager St. Balto. Md.</b></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>Nov. 23-1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b></p>					
		<p>23d. LOCATION (City, town or county) (State) <b>Dundalk, Maryland</b></p>							
<p>24. FUNERAL DIRECTOR <b>John J. Duda, Dundalk, Maryland 21222</b></p>				<p>25a. REC'D BY REGISTRAR <b>NOV 23 1966</b></p>					
				<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>					





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(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15341 CERTIFICATE OF DEATH 15340

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>6 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dulaney-Towson Nursing Home, 111 West Rd. Towson, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>Dallas</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dallas</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>M.</b> Last <b>Murphy</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1887</b>	
9a. AGE (In years last birthday) <b>79</b> yrs.		9b. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Marlin Fire Arms</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Malden, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James MURPHY</b>		14. MOTHER'S MAIDEN NAME <b>Ellen (NOT KNOWN)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>113 05 1059</b>		17. INFORMANT <b>Dorothy M. Estill, Towson, Md. 21204</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>coronary heart disease</b> DUE TO (c) <b>underlying cause last.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Week</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> to <b>11/21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> 19 <b>66</b> , and that death occurred at <b>4:30</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>William F. Fritz</b> 22c. PHYSICIAN'S NAME (Type) <b>William F. Fritz</b>				22b. DATE SIGNED <b>11/21/66</b>		22d. ADDRESS <b>William F. Fritz</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

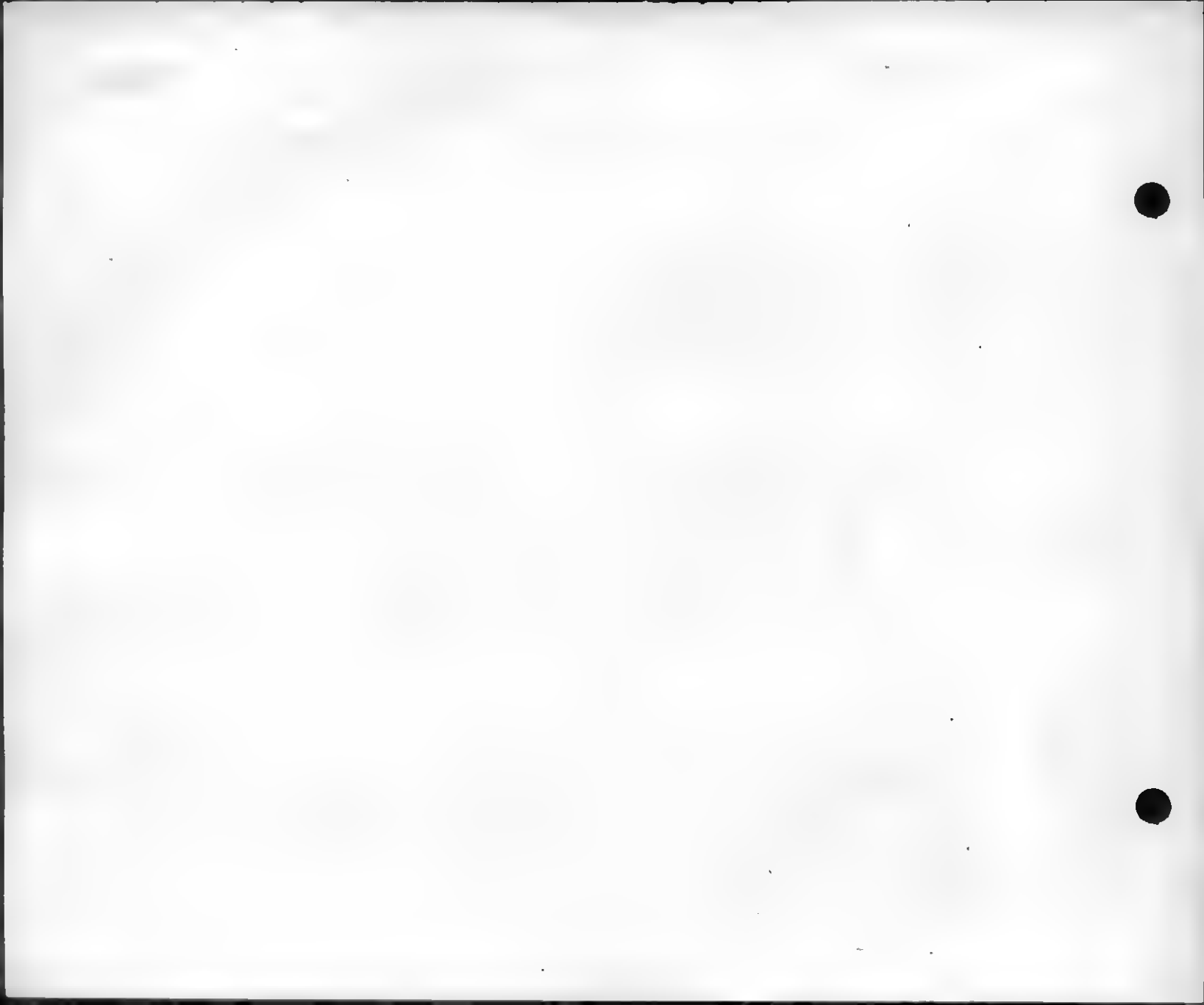
15342

15341

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>9 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MASONIC HOME</b>		d. STREET ADDRESS <b>not known</b>	
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>C</b> Last <b>NEWMAN</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/1882</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>F.L. CORKRAN</b>		14. MOTHER'S MAIDEN NAME <b>JULIA SHAFFER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-54-6541</b>	
17. INFORMANT <b>Masonic Home Records</b>		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASPIRATION BROWCHOPNEUMONIA</b> 4. DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CEREBRAL SCLEROSIS</b> (c) <b>CEREBRAL SCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>NOV 27/66</b> <b>NOV 28, 1966</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 15, 1965</b> to <b>NOV 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>NOV 28, 1966</b> , and that death occurred at <b>5:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>JAMSHID HAMED, MD</b> M.D.		22b. DATE SIGNED <b>NOV 28/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMSHID HAMED, MD</b>		22d. ADDRESS <b>MASONIC HOME</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Maryland</b>	
24. FUNERAL DIRECTOR <b>Will. Cook-Brooks Towson</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. J. Jones</b>		25c. REGISTRAR'S SIGNATURE <b>J. J. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It should be removed, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15343

CERTIFICATE OF DEATH

15342

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>2008 Wilhelm Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>B.</u> Last <u>Nissley</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1911</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Nissley</u>		14. MOTHER'S MAIDEN NAME <u>Lula Baltzell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>187-10-8984</u>	
17. INFORMANT <u>Glady's Nissley</u>		Address <u>2008 Wilhelm St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the liver w/ly</u> DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>7 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>0</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> , 19 <u>66</u> , to <u>11-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-31</u> , 19 <u>66</u> , and that death occurred at <u>6:00</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.C.G.H.</u>		22d. ADDRESS <u>Old Court Rd. Randallstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE Md.</u>
24. FUNERAL DIRECTOR <u>C. L. Schwab Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Francis H. Miller</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>NOV 3 1966</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

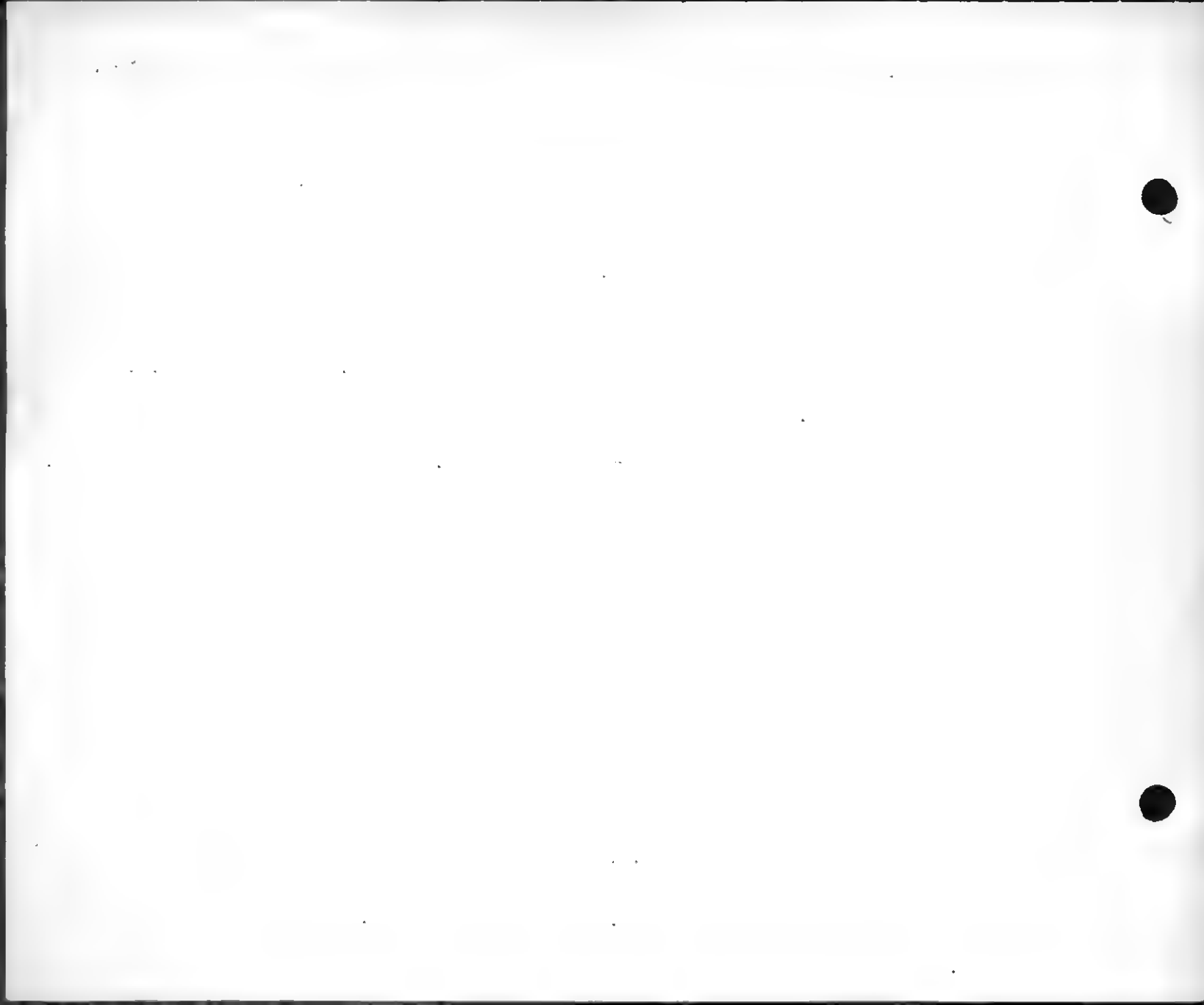
15344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15343

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks-rural</b>			c. LENGTH OF STAY IN 1b <b>6 months</b>			c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Sparks - rural</b> 031	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Walters Lane</b>				d. STREET ADDRESS <b>Walters Lane</b>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>E.</b> Last <b>Noel</b>				4. DATE OF DEATH Month <b>11</b> Day <b>27</b> Year <b>66</b>			
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11/4/33</b>	9 AGE (In years last birthday) yrs <b>33</b>	F UNDER 1 YEAR Months <b>1</b> Days <b>19</b>		F UNDER 24 HRS Hours <b>19</b> Min <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Sparks, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence G. Cole</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Thacker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>214-30-6187</b>		17. INFORMANT <b>Harry F. Noel</b> Address <b>Walters Lane Sparks, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Rheumatic heart disease</b> 1.6X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Partial</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Partial</b>					20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11/27/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James Episcopal Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Monkton, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd, 21204</b>				25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

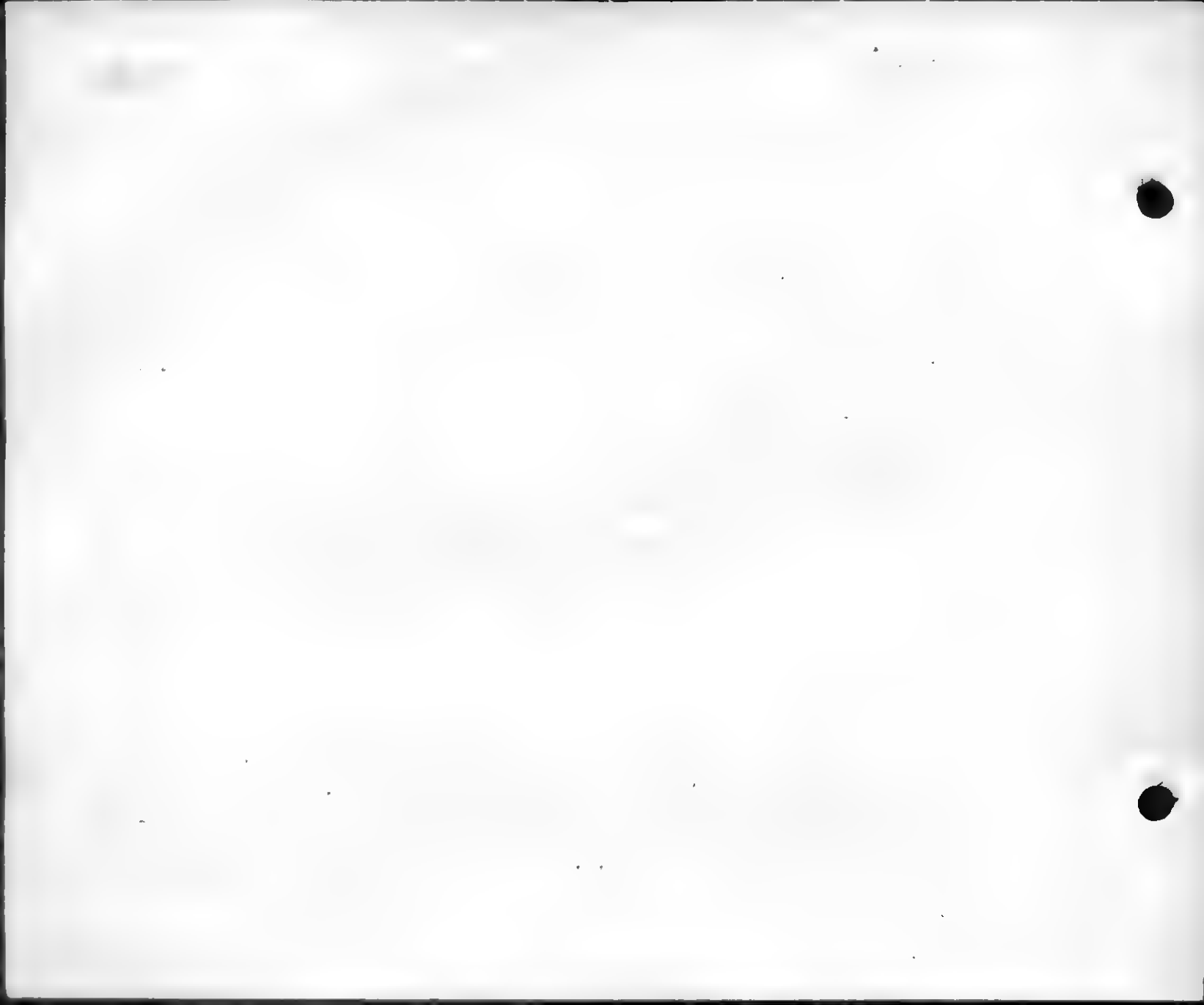
15345

## CERTIFICATE OF DEATH

15344

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>5yr6mthldy</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Parkton</b> <span style="float: right;">03.1</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Rayville Road - Route #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print*) First <b>Mary</b> Middle <b>Noel</b> Last <b>Noel</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>19 66</b>			
5 SEX <b>female</b>		6 COLOR OR RACE <b>white</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>March 1, 1879</b>	
9 AGE (In years last birthday) <b>87</b> yrs		10a US. AL OCC. PATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		11 BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>	
12a US. AL OCC. PATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		11 BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Moses A. Greenstreet</b>				14. MOTHER'S MAIDEN NAME <b>Frances</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16 SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT Address <b>Records : SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> 4 x l l 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>						INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>5 yrs</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>May 1</b> , 19 <b>61</b> to <b>Nov. 3</b> , 19 <b>66</b> that <del>it</del> (we) last saw the deceased alive on <b>Nov. 3</b> , 19 <b>66</b> , and that death occurred at <b>3:35</b> p.m. from causes on and on the date stated above							
22a. SIGNATURE <i>Anthony J. Young</i>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>11-3-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS</b>		23d. LOCATION (City or town) (County) (State) <b>HOWARD CO. MD</b>	
24 FUNERAL DIRECTOR <b>S Mac Nab</b>				ADDRESS <b>301 Frederick Rd Balt 21228 Md</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

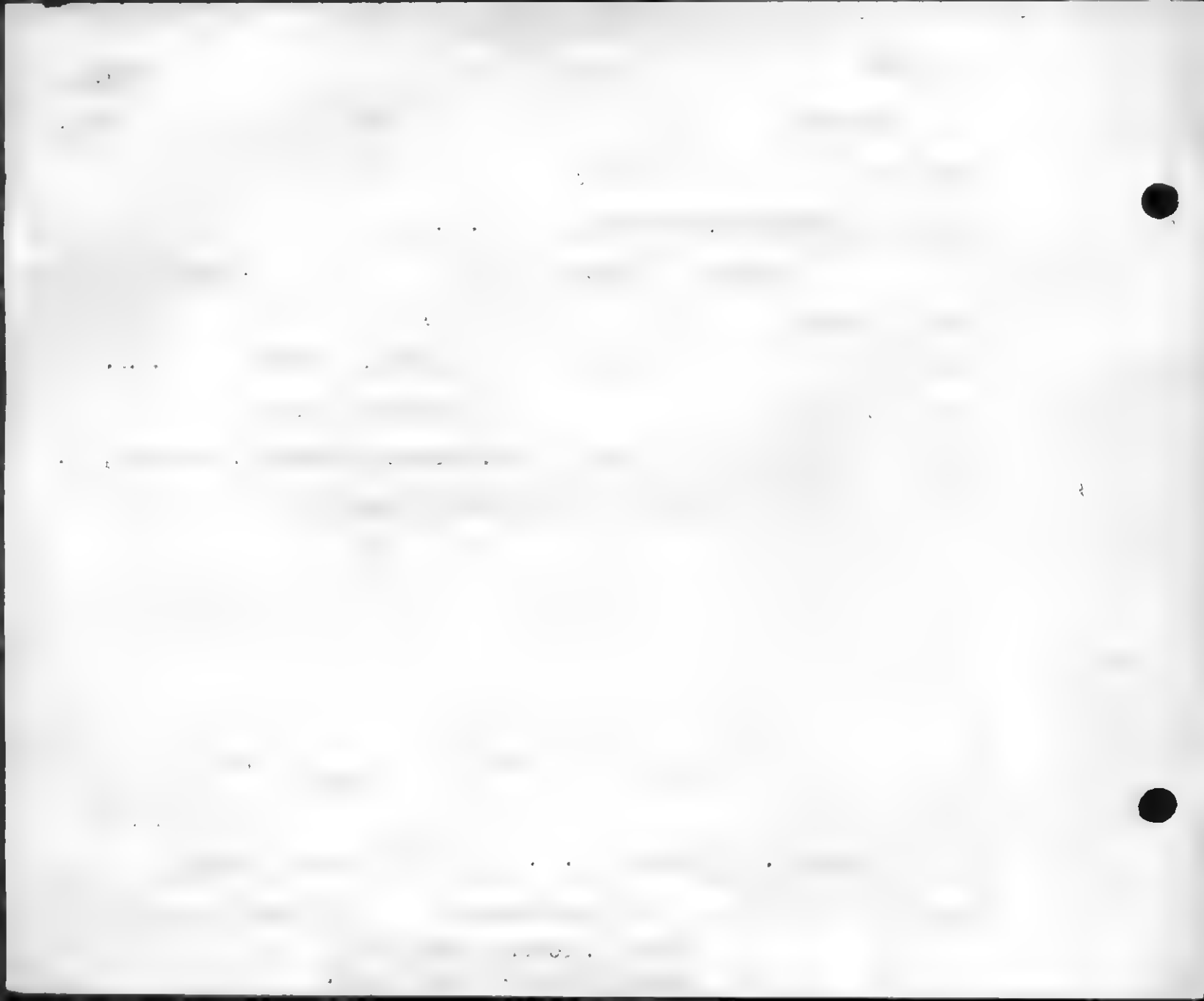
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15346

CERTIFICATE OF DEATH

15345

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>28 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>P. O. Box 743</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>VINCENT RANDOLPH NOTO</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 17 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 17, 1919</b>		9. AGE (In years last birthday) yrs <b>47</b>	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appliances</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>SALVATORE NOTO</b>				14. MOTHER'S MAIDEN NAME <b>SALVATRICE CIMINO</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>216 03 85 38</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE COLON WITH METASTASES</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/21/66</b> , 19__, to <b>11/17/66</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/17/66</b> , 19__, and that death occurred at <b>11:20 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>George C. McElpatrick</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/22/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>GEORGE J. BONCE FUNERAL HOME</b> <b>RITCHIE HIGHWAY, BALTIMORE, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

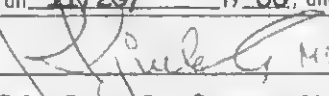
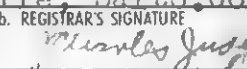
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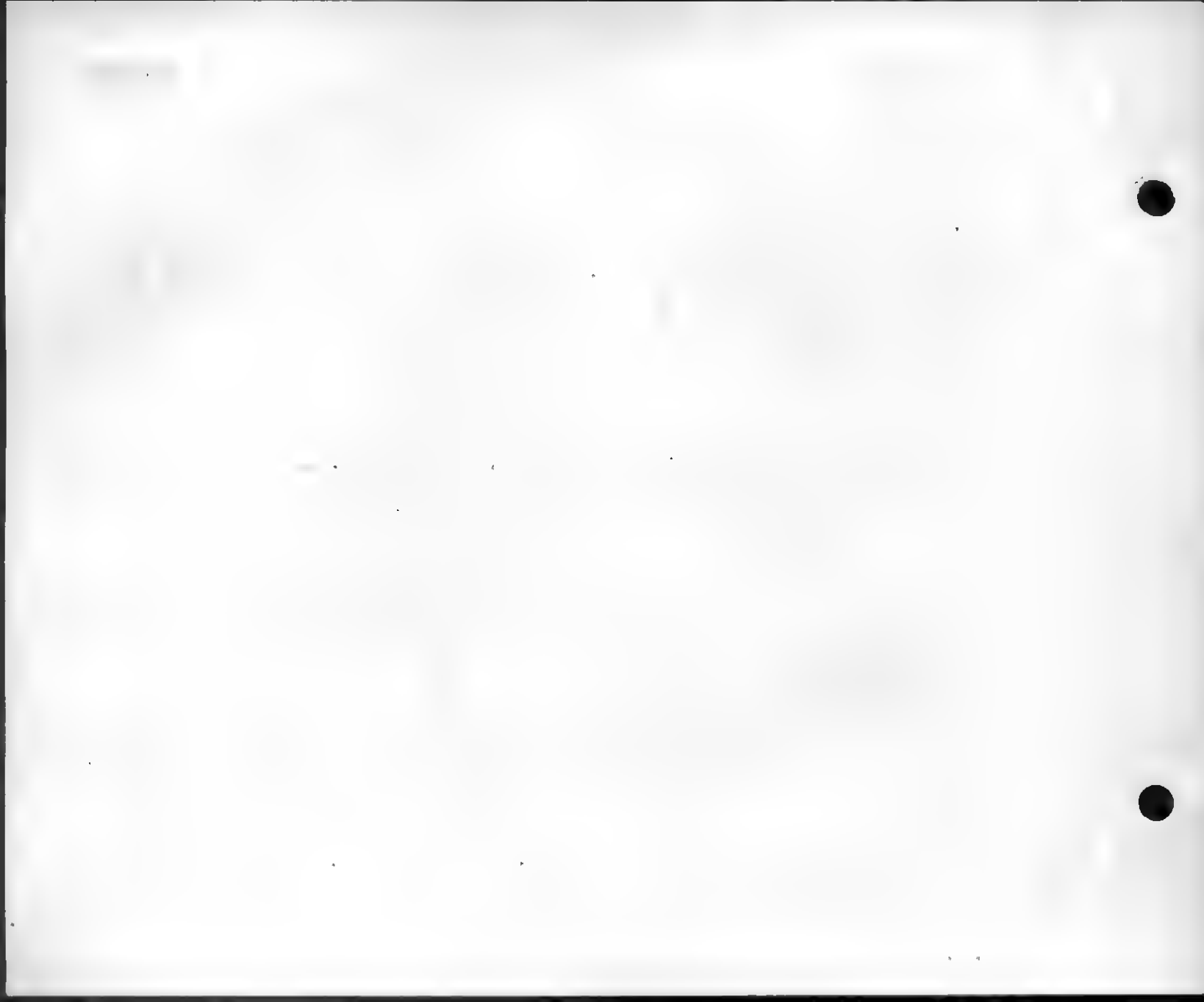
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15347

15346

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21218</b>		d. STREET ADDRESS <b>3908 N. Charles St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>R.</b> Last <b>NOVAK</b>						4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1966</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 25, 1885</b>		9. AGE (In years last birthday) <b>81</b> yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Mins <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Mins <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (county & State, or foreign country) <b>Boston, Massachusetts</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Abraham Rogers</b>						14. MOTHER'S MAIDEN NAME <b>Josephine Plummer</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>220-44-8365</b>		17. INFORMANT <b>Mrs. Wm. F. Schmick, 315 Overhill Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral confluent bronchopneumonia</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction.</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/8/</b> 19 <b>66</b> , to <b>11/28/</b> 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/28/</b> 19 <b>66</b> , and that death occurred at <b>8:30</b> M, from causes and on the date stated above.													
22a. SIGNATURE 						22b. DATE SIGNED <b>11/29/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>					
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/30/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>				23d. LOCATION (City or town) (County) (State) <b>Pikesville, Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 30 1966</b>		25b. REGISTRAR'S SIGNATURE 					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15348 CERTIFICATE OF DEATH 15347

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
c. LENGTH OF STAY IN 1b <u>4 mo.</u>		d. STREET ADDRESS <u>2121 Graythorn Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2121 Graythorn Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANTHONY W. NOWICKI</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/13/20</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR: Months <u>46</u> Days <u>0</u> Hours <u>0</u> M. n. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Time Keeper</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Corp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Nowicki</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jurkowski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-14-2688</u>	
17. INFORMANT <u>Mrs. Helen Patricia</u>		Address <u>1227 Neighbors Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>Arteriosclerotic Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6:00</u> <u>1966</u> to <u>Nov 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 29, 1966</u> , and that death occurred at <u>A</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John G. Orth, M.D.</u>		22b. DATE SIGNED <u>12/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN G. ORTH</u>		22d. ADDRESS <u>8014 Philadelphia Rd. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M.F. SADOWSKI &amp; SONS</u>		25a. REC'D BY REGISTRAR <u>DEC 2 1966</u>	
ADDRESS <u>1808 EASTERN AVE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15349

MARYLAND STATE DEPARTMENT OF HEALTH

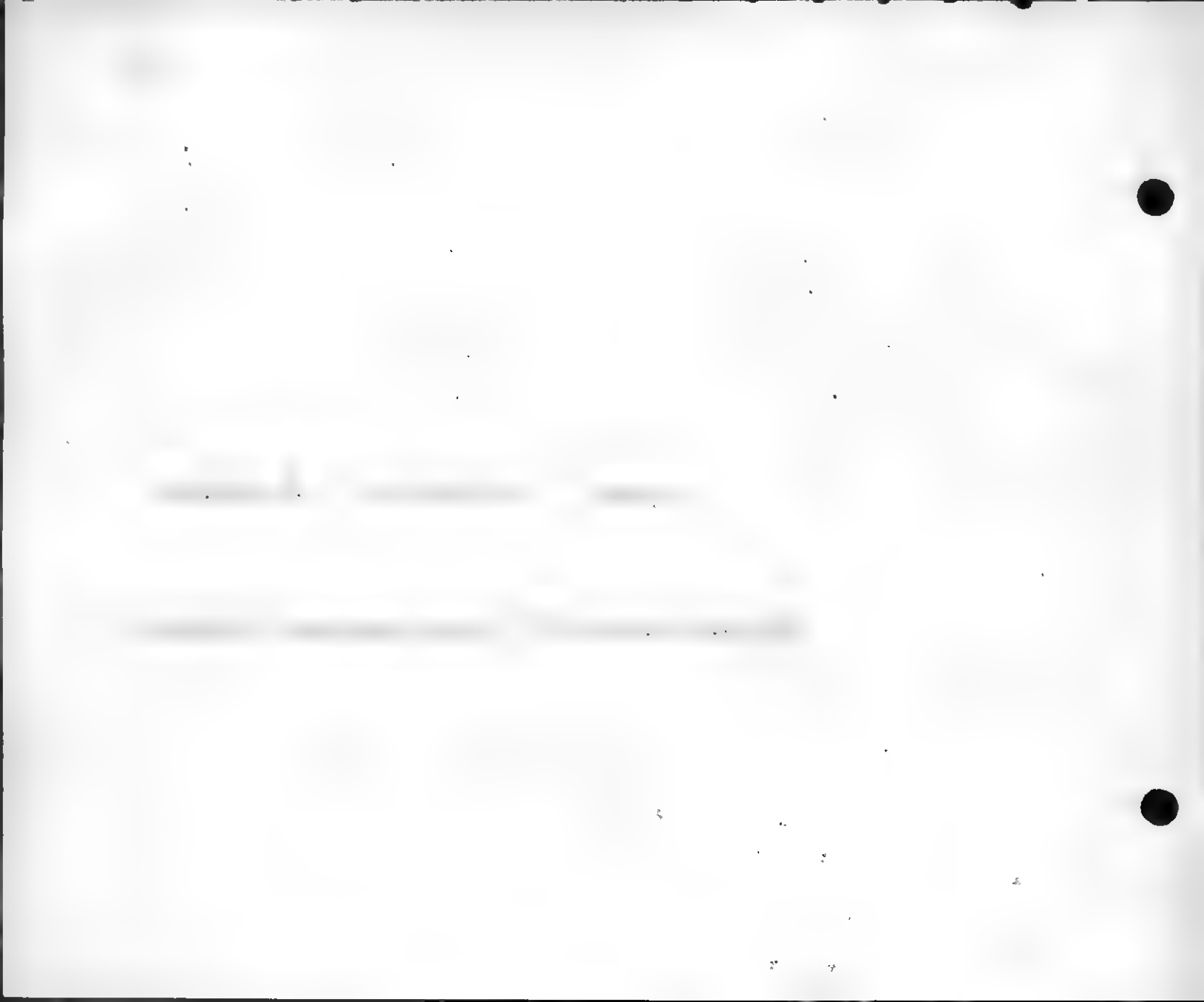
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15348

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE TOWSON</b>				c. LENGTH OF STAY IN 1b <b>5 hrs. 15 min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>				d. STREET ADDRESS <b>401 WEST TIMONIUM RD.</b>			
3. NAME OF DECEASED (Type or print) <b>JAMES SAMUEL NUSSEAR</b>				4. DATE OF DEATH <b>NOV. 21 1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W or CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-18-1884</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARCHITECT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>LUTHERVILLE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES SAMUEL NUSSEAR, SR.</b>				14. MOTHER'S MAIDEN NAME <b>CLARA VIRGINIA NUSSEAR RIDGELY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-18-8709</b>		17. INFORMANT (Hospital and Address Road, Towson, Md family: Mr. Wm. N. S. Pugh, 1002 Dulany Valley	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA BILATERAL</b> 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DUE TO</b> (c) <b>DUE TO</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-21-</b> , 19 <b>66</b> , to <b>11-21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>66</b> , and that death occurred at <b>8:50 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Evelyn L. Ramos, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>EVELYN L. RAMOS</b>				22d. ADDRESS <b>GBMC, 6701 N. CHARLES ST., BALTO.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>TOWSON, BALOT. CO., MD.</b>	
24. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co., 108 J. North Av., Balto.</b>				25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

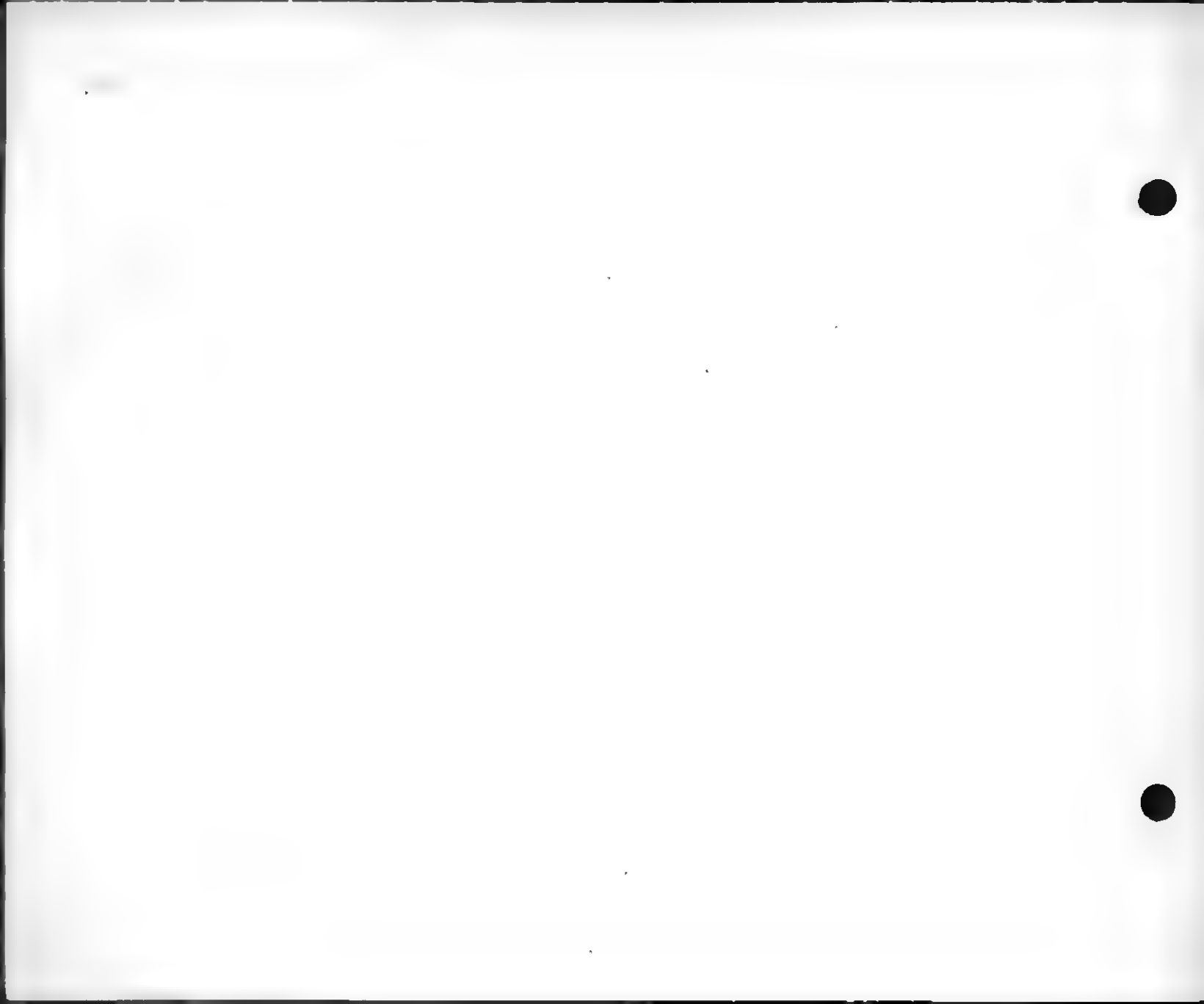
FOR STATE  
HEALTH DEPT.

15350

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15349

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson-rural</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>3573 Juneway</b>			
3 NAME OF DECEASED (Type or print) <b>Kathleen A. O'Mailey</b>				4 DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>19 66</b>			
5. SEX <b>female</b>	6 CO. OR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/17/46</b>	9 AGE (in years last birthday) <b>20</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reuben I. Donnelly Adv.</b>		11 BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Brayden O'Mailey</b>				14. MOTHER'S MAIDEN NAME <b>Genevieve Gordon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Brayden O'Mailey, father, above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia following bilateral leg fractures</b> Cond. 1 only, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Pulmonary and systemic fat embolism following</b> (c) <b>fractures of legs.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>pedestrian struck by car</b>					
20c. TIME OF INJURY Month, Day, Year <b>? 11 10 19 66</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>(Towson) Baltimore Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>11/14/66</b>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

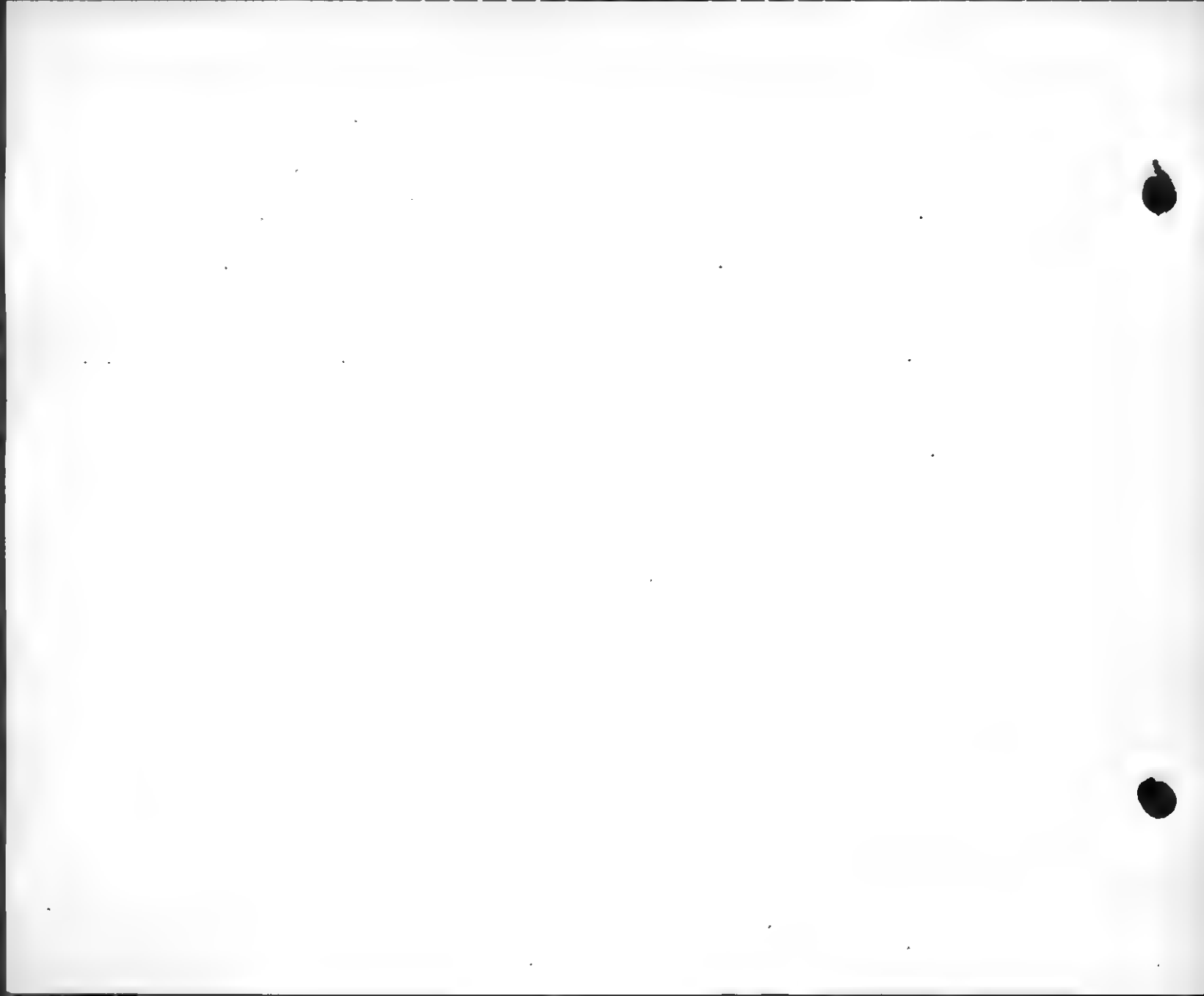
**15351**

**15350**

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d. STREET ADDRESS <b>19 Wilfred Ct.</b>	
3. NAME OF DECEASED (Type or print) <b>George H. Pardoe</b> First Middle Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> , Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during normal working hours (if retired)) <b>Ins. Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>	9. AGE (in years last birthday) yrs <b>87</b>
11. BIRTHPLACE (State or foreign country) <b>Lusby, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Pardoe</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Brady</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217 01 6470</b>	
17. INFORMANT <b>Charles G. Pardoe, Towson, Md.</b> Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Compensation</b> DUE TO <b>Inter-vertebral Fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of left hip</b> DUE TO (c) <b>of left hip</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b> <b>16 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell while walking on Home</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7:30</b> p.m. <b>11/29/66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>
20f. (City or town) <b>Towson Baltimore Md</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inquest <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>11/26/66</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 29, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b> ADDRESS <b>Towson, Md.</b>		25a. REC'D BY REG. STRAR DATE <b>DEC 1 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



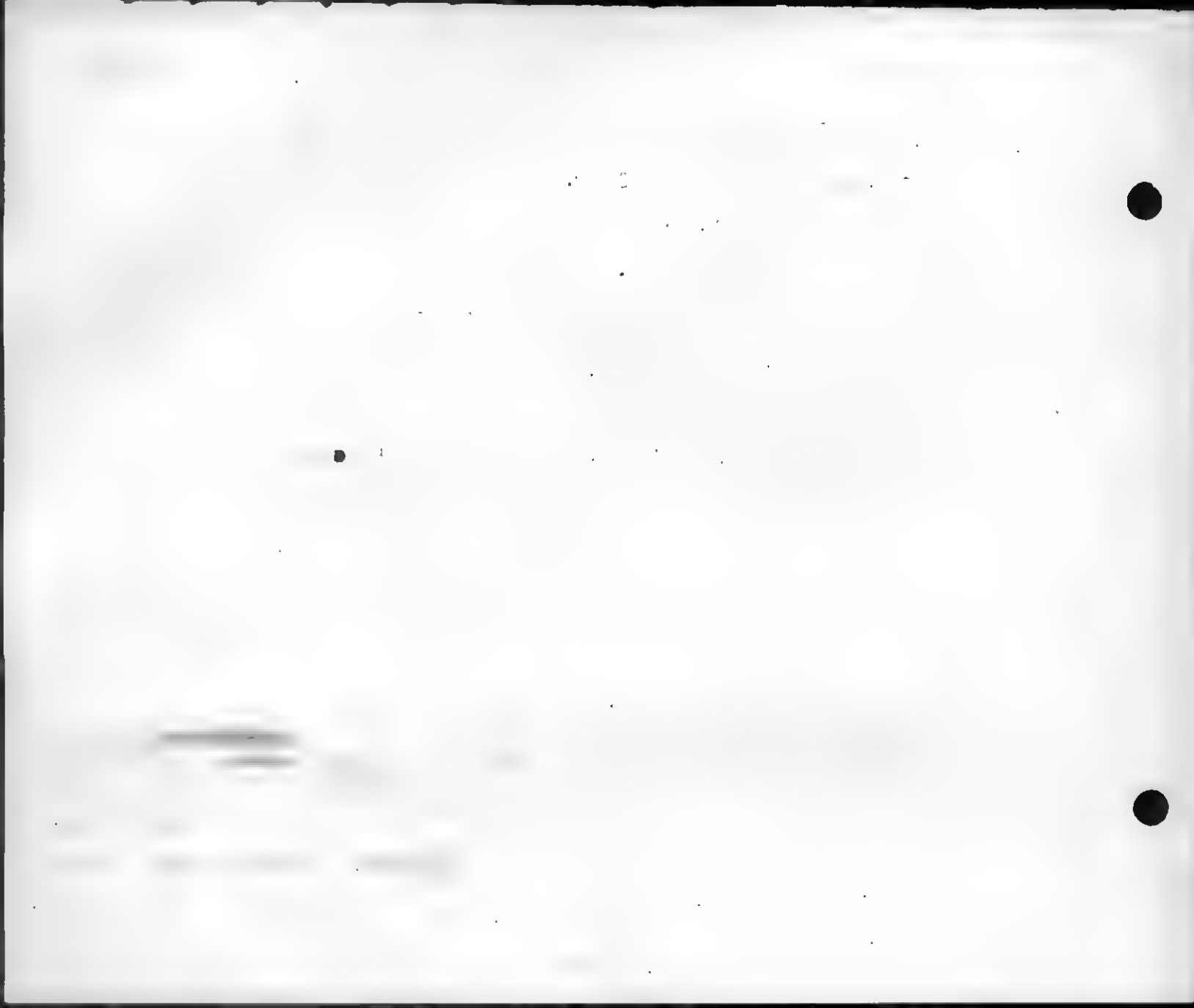
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 9, 10, 13, 14 Film 5305 11/29/66 mh

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>39 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GBMC 6701 NORTH CHARLES STREET</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARKS, MARYLAND</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>B.</b> Last <b>PARKS</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-1885</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>17</b>	11. IF UNDER 24 HRS. Hours <b>16</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>St. Rds. Foreman-ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore County</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Parks</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Robinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-36-8620</b>	
17. INFORMANT <b>PATIENTS'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>chronic pulmonary emphysema, severe</b> DUE TO (c) <b>carcinoma of bladder, malignant tumor of rt. chest wall</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>carcinoma of bladder, malignant tumor of rt. chest wall</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>2 wks.</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Nov. 16</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 7</b> , 19 <b>66</b> , to <b>Nov. 16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov 16</b> , 19 <b>66</b> , and that death occurred at <b>6:30</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Chiu-chin Shih</b>		22b. DATE SIGNED <b>Nov. 17, 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHIU-CHIN SHIH</b>		22d. ADDRESS <b>GREATER BACCO MED. CENTER</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-20-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>JESSOPS CHURCH</b>		23d. LOCATION (City, town or county) (State) <b>SPARKS MARYLAND</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>Nov 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

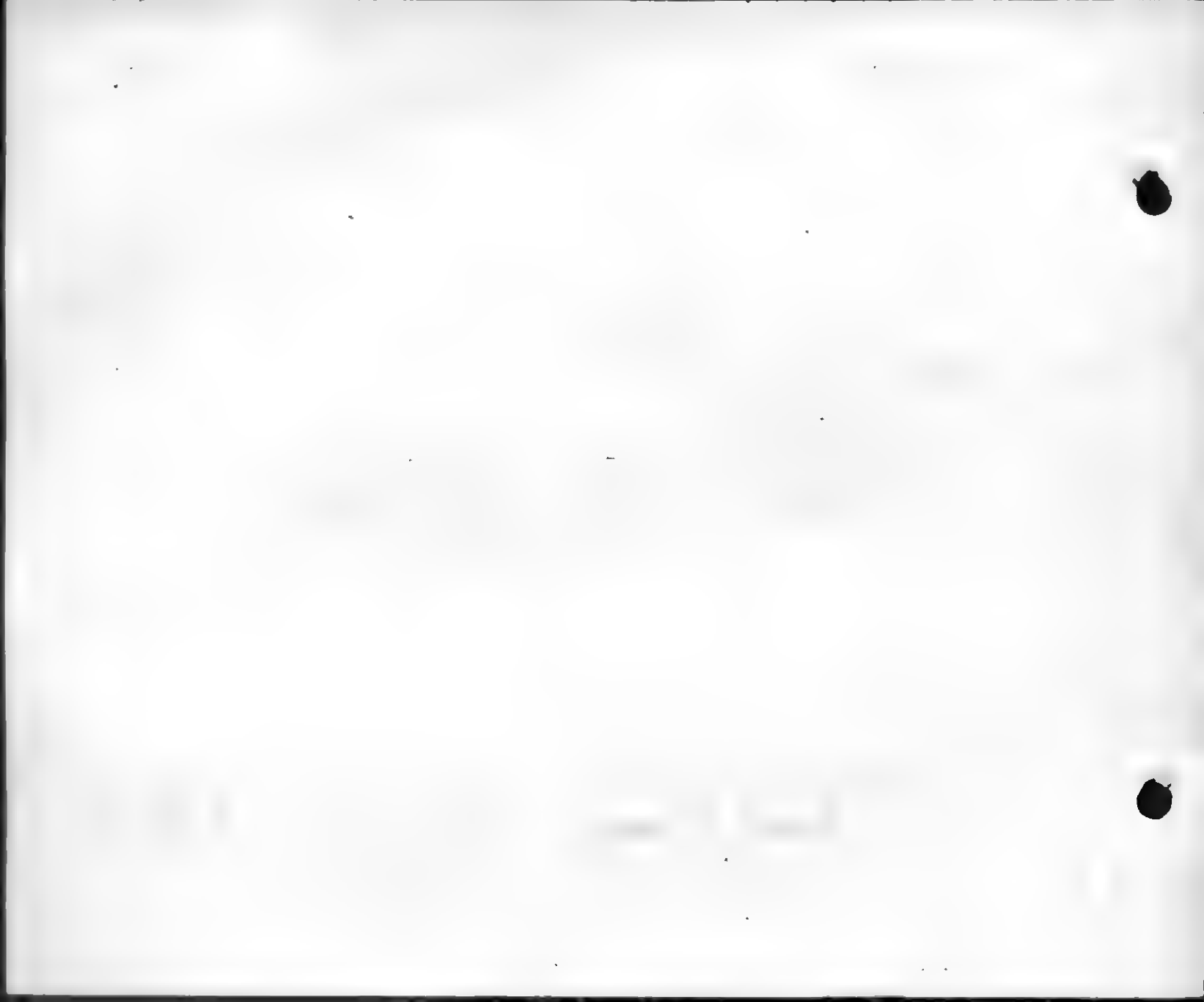
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1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>_____</b> ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>9 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>3805 Bonview Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Pasterfield</b> Last <b>Pasterfield</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>6</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-2-92</b>
9 AGE (In years lost b rthday) <b>74</b> yrs		10 IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min <b>_____</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Steamfitters Local # 438</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Pasterfield</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Unk.</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>212-03-1174</b>		17. INFORMANT Address <b>Helen N. Pasterfield 3805 Bonview Ave. 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe anemia secondary to erythrocytic hypoplasia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>_____</b> (c) <b>_____</b>			INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>_____</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>_____</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>	20f. (City or town) (County) (State) <b>_____</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 21</b> , 19 <b>66</b> , to <b>Nov. 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov. 6</b> , 19 <b>66</b> , and that death occurred at <b>6:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>Nov. 6, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez, M.D.</b>		22d. ADDRESS <b>7620 York Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/9/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 10 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be emitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

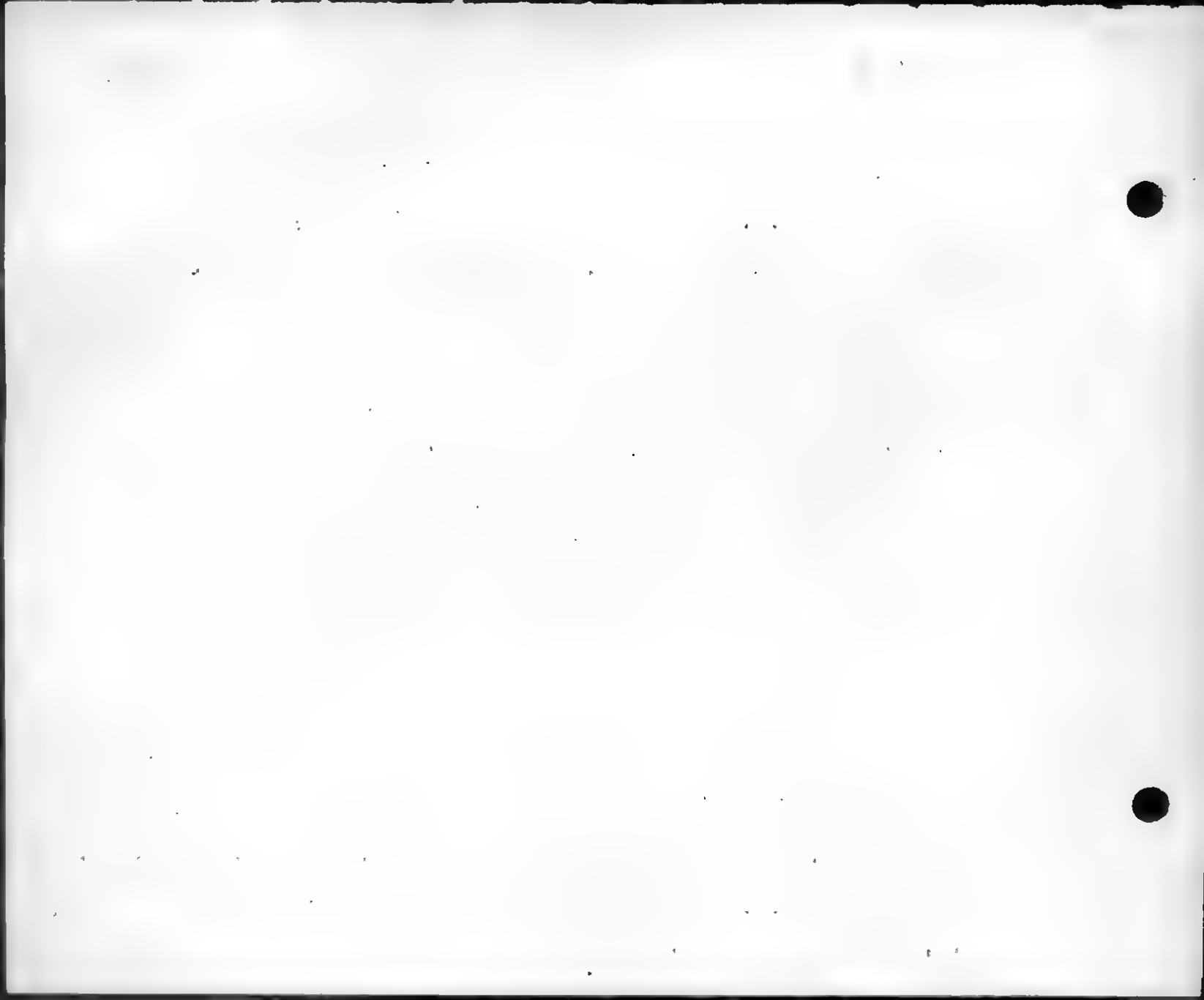
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shady Nook N.H.</b>		d. STREET ADDRESS <b>209 Southway</b>	
3. NAME OF DECEASED (Type or print) <b>Pearl N. Pausch</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-1878</b>
9. AGE (in years last birthday) <b>88</b> yrs.		IF UNOER 1 YEAR IF UNOER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Neal</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Robinson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>213-10-3846B</b>		17. INFORMANT <b>George Pausch</b> Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4330</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis</b> DUE TO (c) <b>Pneumo-pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>42 or 3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1930</b> , 19 to <b>Present</b> , 1966, that (I) (we) last saw the deceased alive on <b>Nov 4</b> , 1966, and that death occurred at <b>2:00</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Wetherbee Fort</b>		22b. DATE SIGNED <b>11-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wetherbee Fort</b>		22d. ADDRESS <b>1118 St. Paul St. Balto., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-7-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>
23d. LOCATION (City, town or county) (State) <b>Pikesville Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</b>		25b. REGISTRAR'S SIGNATURE <b>W. Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

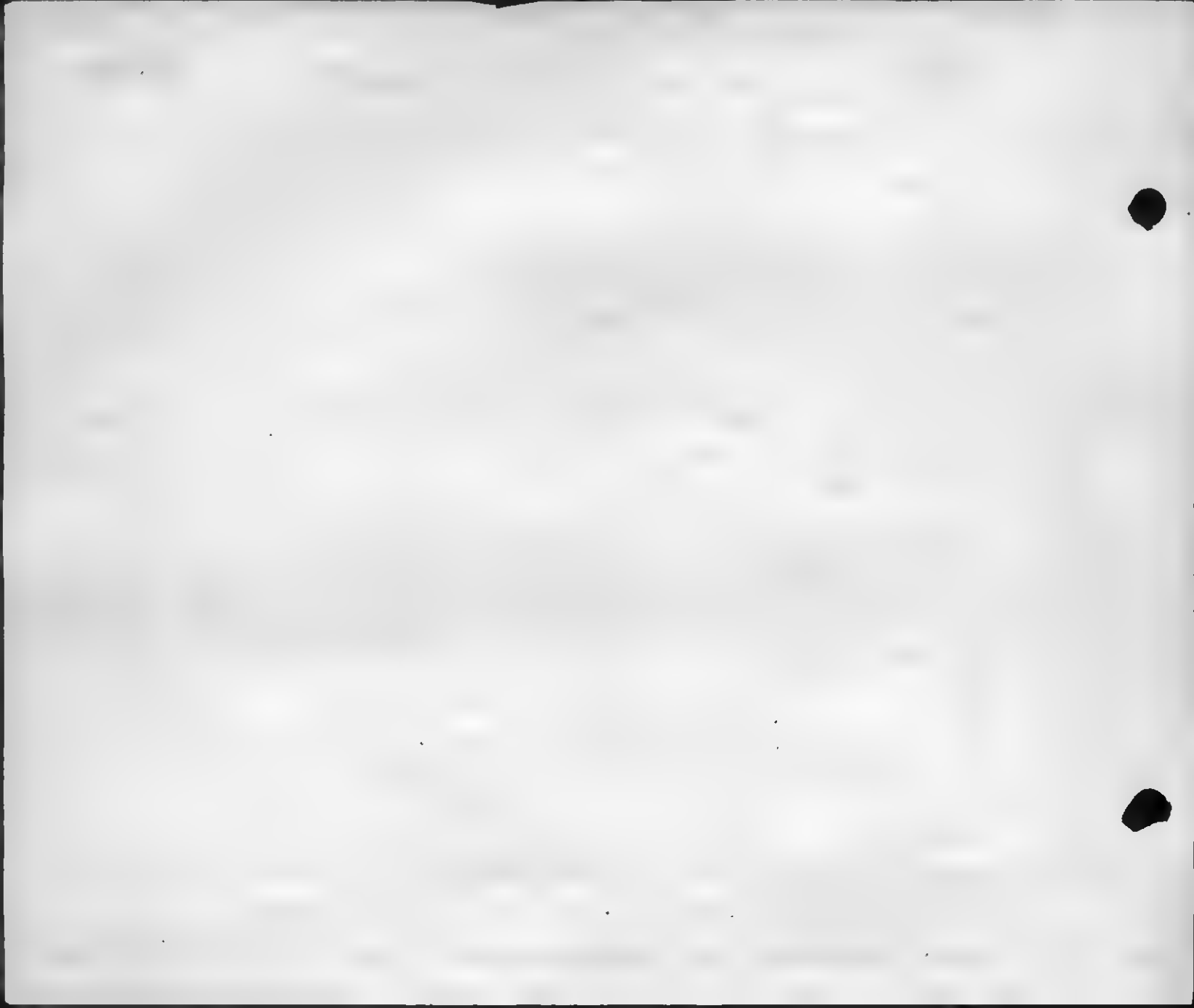
## CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> c. LENGTH OF STAY IN 1b <u>56 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>J. M. Pearce Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> d. STREET ADDRESS <u>J. M. Pearce Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>BERTIE</u> Middle <u>HOPE</u> Last <u>Perdue</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>18</u> Year <u>1966</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9 August 1877</u>
<b>9. AGE</b> (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Taylor, Maryland, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joshua Hope</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Olivia Hutchins</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>215-48-2062</u> <b>17. INFORMANT</b> <u>Mrs. J. Cockey Jr.</u> Address <u>Monkton Md. 21111</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town) (County) (State)</b> <u>  </u>
<b>21. I certify that (I) (this hospital), attended the deceased from</b> <u>August 17, 1966</u> <b>to</b> <u>November 18, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>17 November 1966</u> <b>and that death occurred at</b> <u>3:15 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Walter T. Kees</u>		<b>22b. DATE SIGNED</b> <u>18 November 1966</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>WALTER T. KEES</u>		<b>22d. ADDRESS</b> <u>Cockeyville Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>11/20/1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. James</u>	<b>23d. LOCATION (City, town or county) (State)</b> <u>Monkton Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Kurtz</u>		<b>25. REC'D BY REGISTRAR</b> <u>NOV 21 1966</u>	
<b>ADDRESS</b> <u>Jarrettsville, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

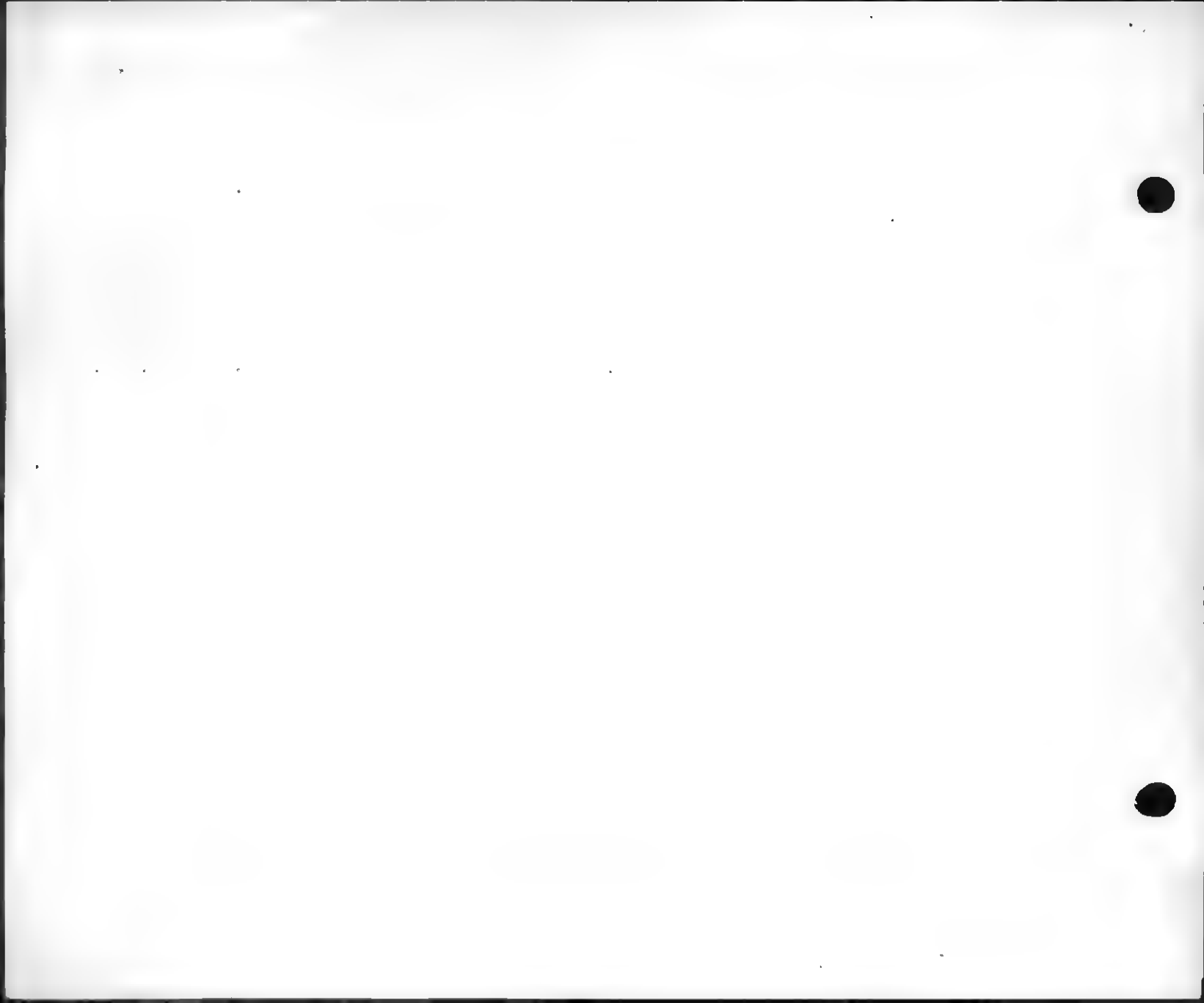
15356

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15355

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyde Park Essex Md.</b>				c. LENGTH OF STAY IN 1b <b>13.1</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1405 Waterford Road</b>				d STREET ADDRESS <b>1405 Waterford Road</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>FRANK D. Paul PERRERA</b>				4 DATE OF DEATH Month Day Year <b>11 9 19 66</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 25th -14 52</b>		9 AGE (In years last birthday) <b>54</b>		10 IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>		11 BIRTHPLACE (State or foreign country) <b>Thompsonville Conn.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Salvatore Perrera</b>				14 MOTHER'S MAIDEN NAME <b>Concetta De Martina</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>100-10-3825</b>		17 INFORMANT Address <b>Mrs. Nancy Perrera Wife-1405 Waterford Rd.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART I (a) <b>Fatty Metamorphosis of Liver</b>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rudiger Breiteneker</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11/9/66</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county) <b>Baltimore Md.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>November 12-66</b>		23c. NAME OF CEMETERY OR CREMATOR <b>HOLLY HILL MEMORIAL PARK</b>		23d LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>	
24 FUNERAL DIRECTOR <b>Frank Della Uoce</b>		ADDRESS <b>322 S. High St.</b>		25a REC'D BY REGISTRAR <b>NOV 10 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death



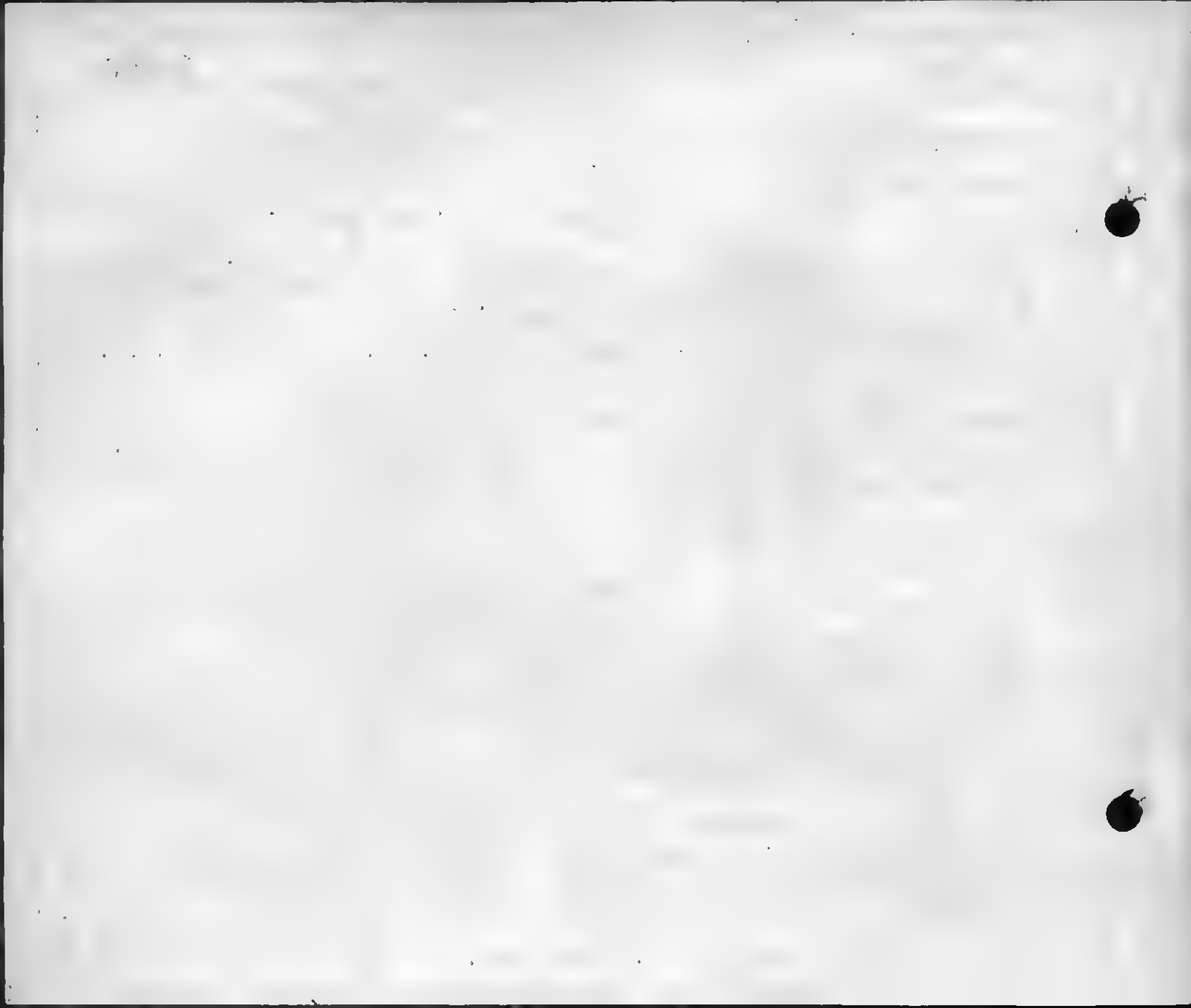


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>3yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House In The Pines Nursing Home</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1034 S. Hanover St.</u>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leonard</u> <u>Plitt</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>Nov.</u> <u>23</u> <u>1966</u> Month Day Year				
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 2, 1881</u>		<b>9. AGE (In years last birthday)</b> <u>85</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Trucker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self-employed</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>August Plitt</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Marie Hennigan</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Rensburg</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Chr. Myocarditis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5-22-1964</u> <b>to</b> <u>11-23-1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>11-23-1966</u> , <b>and that death occurred at</b> <u>8 P.M.</u> <b>from the causes and on the date stated above</b>									
<b>22a. SIGNATURE</b> <u>William K. Gallagher</u>					<b>22b. DATE SIGNED</b> <u>11-25-66</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>William K. Gallagher, M.D.</u>					<b>22d. ADDRESS</b> <u>6209 Frederick Ave. Balt. 28 Md.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/26/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Frederick Ave. Balto. Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>KRAUSE FUNERAL HOME</u>					<b>25a. REC'D BY REGISTRAR</b> <u>NOV 28 1966</u>				
<b>ADDRESS</b> <u>1216 S. Charles St.</u>					<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

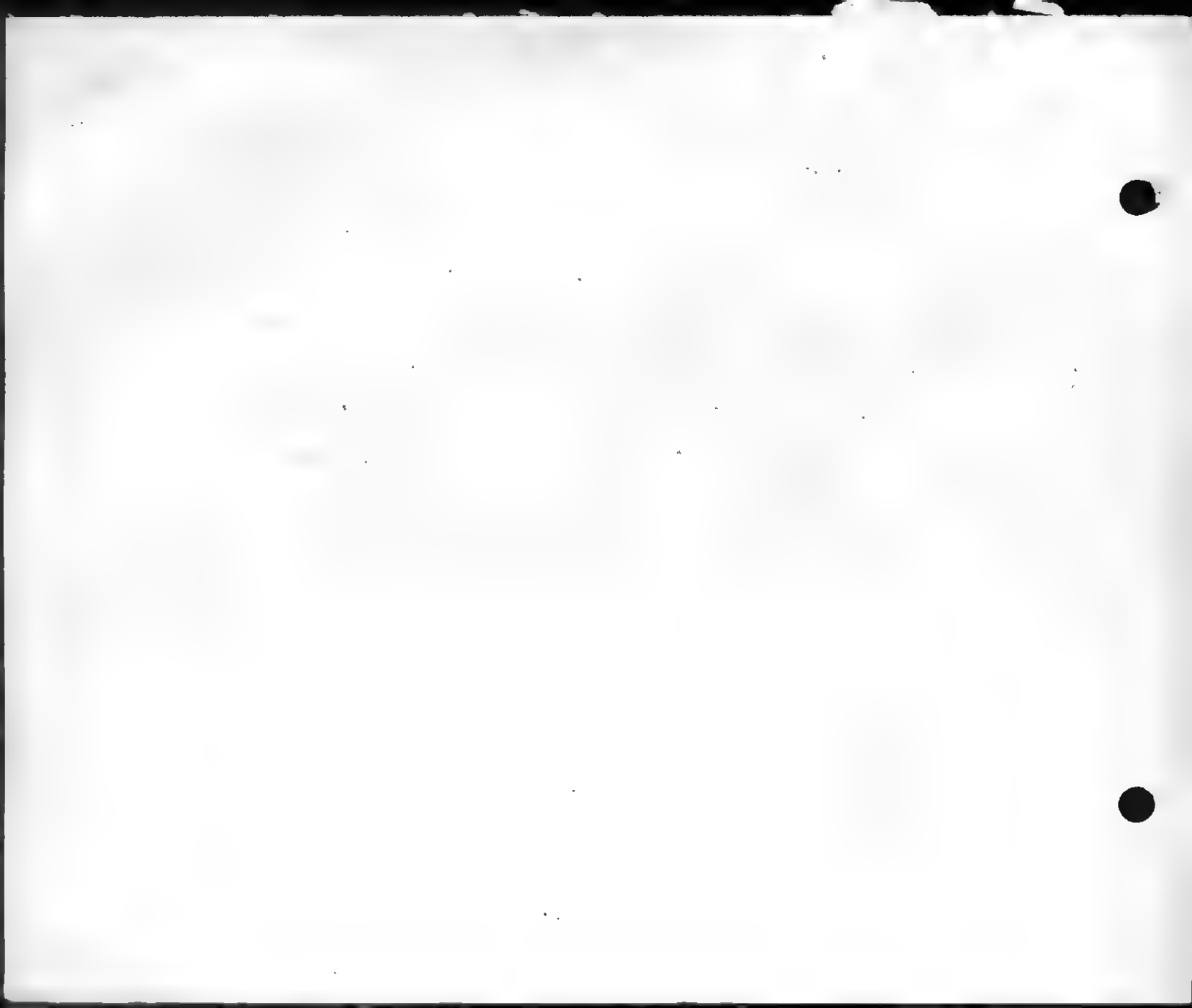
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> 15358 </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  <b>CERTIFICATE OF DEATH</b> </div> <div> 15357 </div> </div>																			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ridgeway Manor</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>332 Lambeth Road 28</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>E.</b> Last <b>Prettyman</b>			4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1966</b>		5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/7/1875</b>		9. AGE (In years last birthday) <b>91</b>		10. UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>		11. UNDER 24 HRS. Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Washington Davis Taylor</b>										14. MOTHER'S MAIDEN NAME <b>Zipporah Bounds</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT Address <b>Mrs. Phyllis Hornfleck 332 Lambeth Road</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dangerous of heart disease</b> (b) <b>Myocardial infarction</b> (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Somnolence</b>															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>November 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>November 14, 1966</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>J. Nelson McKay</b>										22b. DATE SIGNED <b>Nov 17, 1966</b>									
22c. PHYSICIAN'S NAME (Type) <b>J. Nelson McKay, M.D.</b>										22d. ADDRESS <b>6014 Edmondson Ave Balto 28, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>					23b. DATE THEREOF <b>11/18/1966</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>					23d. LOCATION (City, town or county) (State) <b>Seaford, Delaware</b>				
24. FUNERAL DIRECTOR <b>Wm. J. Tubman - Sons</b>										25a. REC'D BY REGISTRAR <b>Nov 18 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

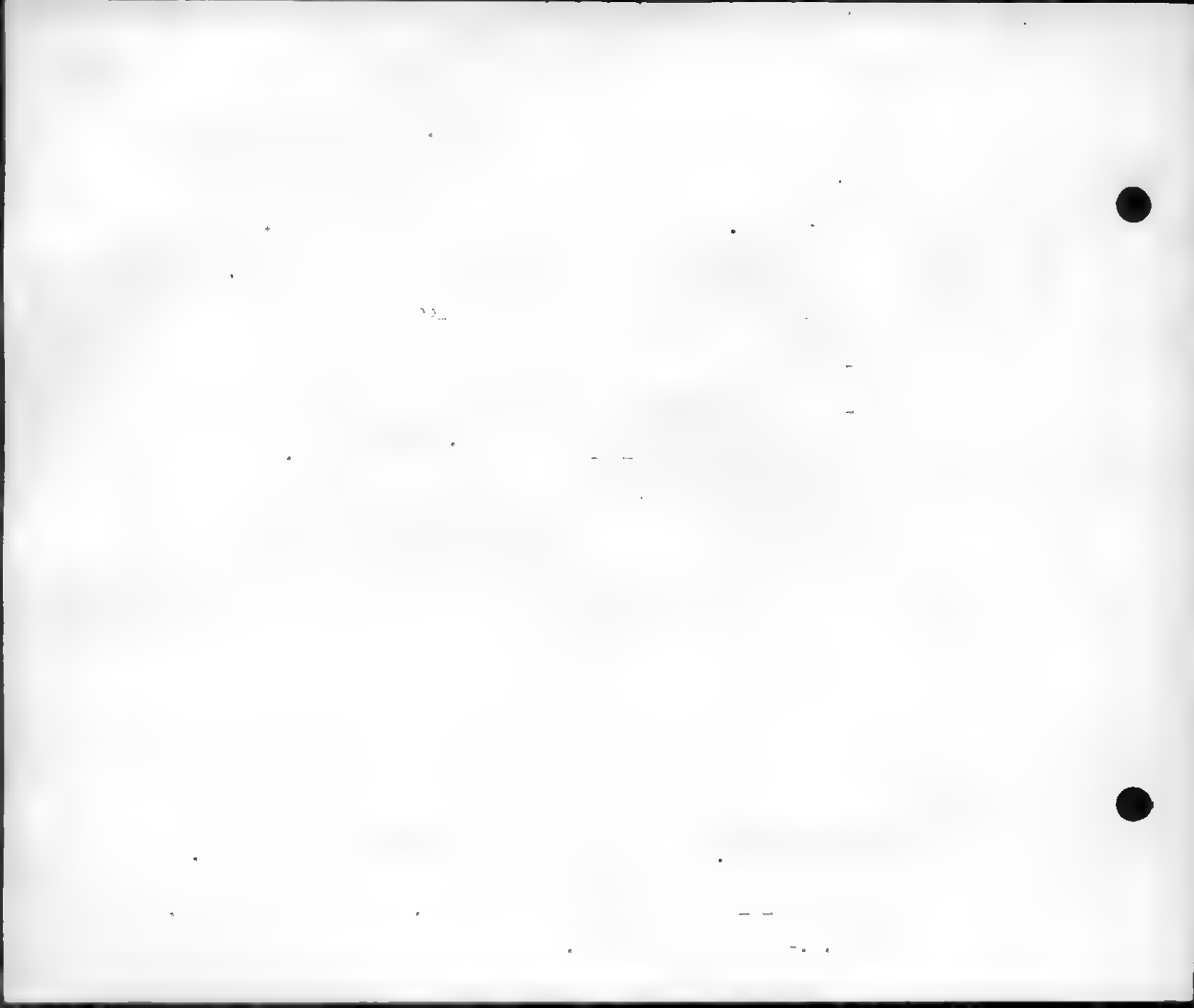
15359

15358

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>03-1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6416 Frederick Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>6416 Frederick Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Stephen Provenza</b> First Middle Last 4. DATE OF DEATH <b>Nov. 30</b> Month Day Year 19 <b>66</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>Wh</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>3-16-99</b> 9. AGE (In years lost birthday) yrs <b>69</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Louisiana</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Late - Rosario Provenza</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO <b>216-32-5764</b>		17. INFORMANT <b>Mrs. Anna Provenza</b> Address <b>6416 Frederick Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> <b>502.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Emphysema chronic bronchitis</b> DUE TO (c) <b>Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>3 3/4</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1964</b> to <b>11/30/66</b> , that (I) (we) last saw the deceased alive on <b>11/30/66</b> 19 <b>66</b> , and that death occurred at <b>9:11 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>A. Calas</b> 22c. PHYSICIAN'S NAME (Type) <b>Andres E. Calas</b>		22b. DATE SIGNED <b>12/3/66</b> 22d. ADDRESS <b>6411 Frederick Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-5-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15360

## CERTIFICATE OF DEATH

15359

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		c. LENGTH OF STAY IN 1b <u>Baynesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8703 Raven Drive #34 Apt. A</u>		d. STREET ADDRESS <u>8703 Raven Drive Apt. A.</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>E.</u> Last <u>Raborg</u>		4 DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1966</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1879</u>
9 AGE (In years last birthday) <u>87 yrs.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafe Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Board of Education of Baltimore</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. C.T. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>James Raborg</u>		14 MOTHER'S MAIDEN NAME <u>Winifred Conroy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>121-05-3665</u>	
17. INFORMANT <u>Rita Schaefer, neice</u>		Address <u>8425 Water Oak Rd. #34.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>NOV</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>OCT 28</u> , 19 <u>66</u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Larry G. Tilley MD</u>		22b. DATE SIGNED <u>11-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Larry G. Tilley</u>		22d. ADDRESS <u>1713 Taylor Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Maryland, Baltimore</u>
24. FUNERAL DIRECTOR <u>Scullin Funeral Home, Inc.</u> <u>3331 Brehms Lane #13</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15361

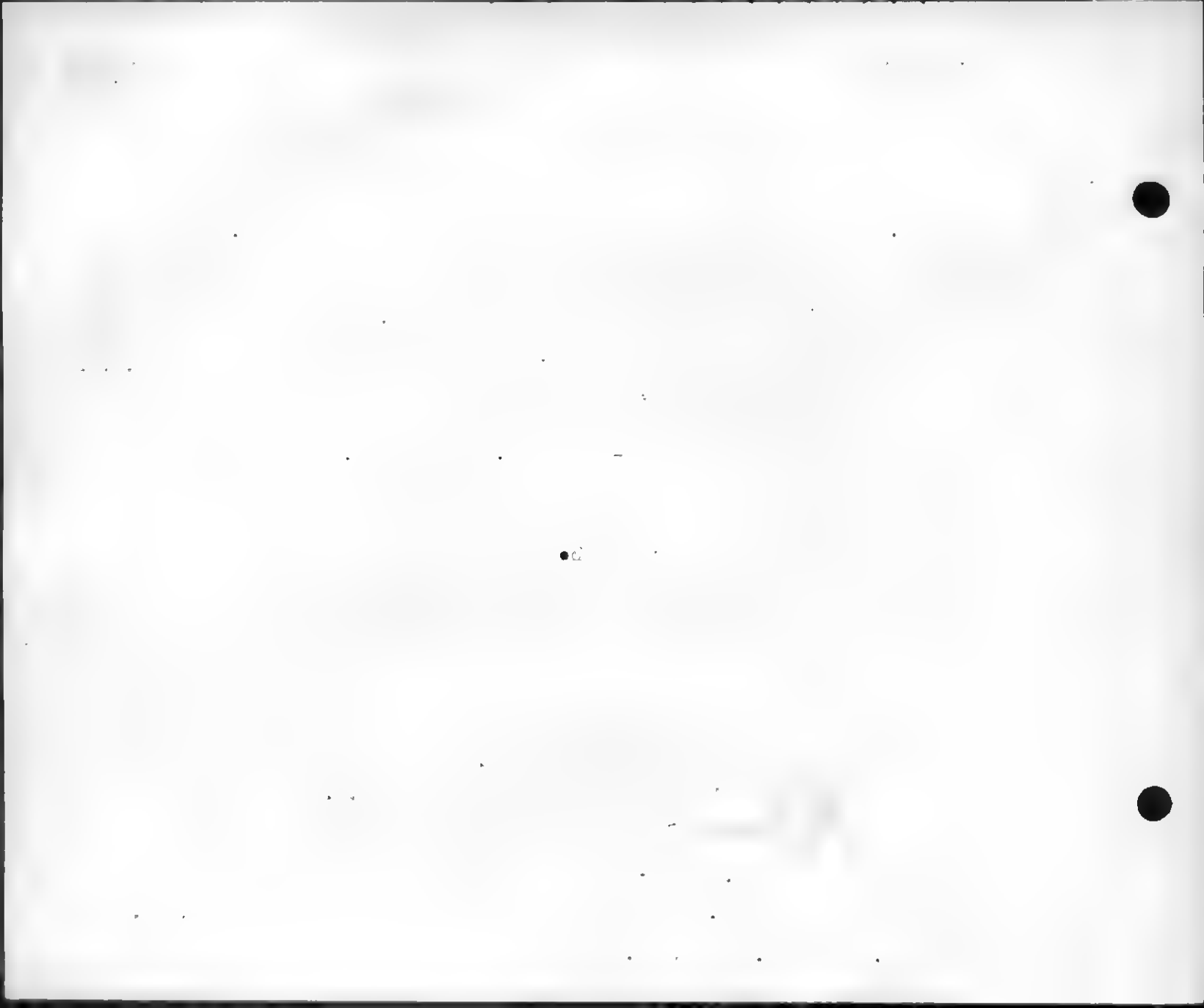
## CERTIFICATE OF DEATH

15360

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #12</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>				d. STREET ADDRESS <u>1262 Beaumont Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Philip Rocco Ranieri</u>				4. DATE OF DEATH Month Day Year <u>November 20 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1913 September 5</u>	
9. AGE (In years lost birthday) yrs. <u>53</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Century Cleaners &amp; Dryers</u>		10b. KIND OF BUSINESS OR INDUSTRY (Manager) <u>(Manager)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Salvatore Ranieri</u>			
14. MOTHER'S MAIDEN NAME <u>Carmela Tripodina</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-01-0034</u>				17. INFORMANT Address <u>Mrs. Josephine M. Ranieri (Same)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18</u> , 19 <u>66</u> , to <u>Nov. 20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 20</u> , 19 <u>66</u> , and that death occurred at <u>2:30 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Nelson A. Villamor</u>				22b. DATE SIGNED <u>Nov. 20 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Nelson A. Villamor</u>	
22d. ADDRESS <u>7620 York Road</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>11/23/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 21 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

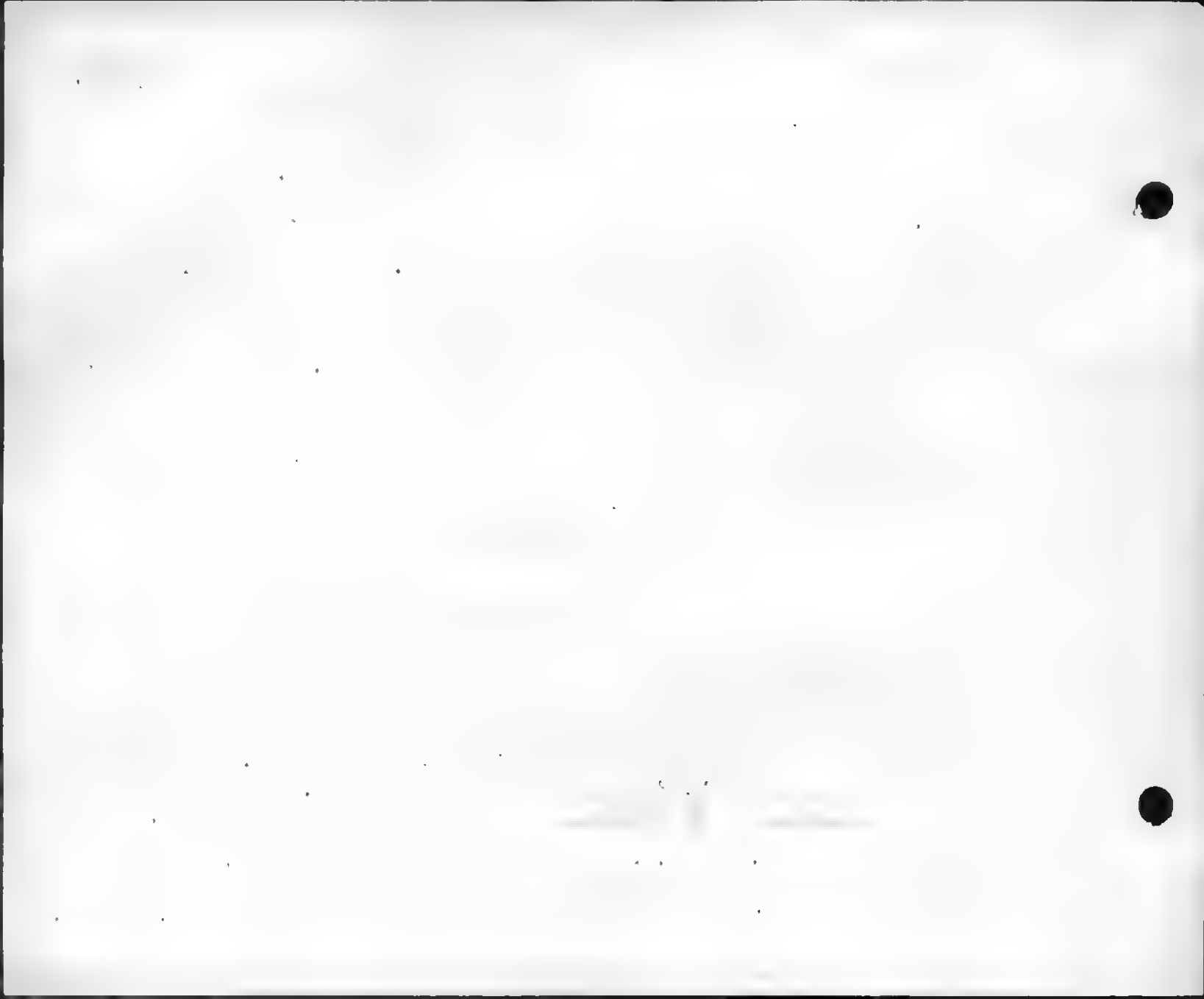
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

15362

CERTIFICATE OF DEATH

15361

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN lb <b>Perry Hall, Md. 21128</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>Box 21, Joppa Rd., Perry Hall</b>	
3 NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Henry</b> Last <b>Reed, Sr.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11/21/82</b>
9a AGE (in years last birthday) <b>84 yrs</b>		9b IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Florist</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Akehurst Brothers</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Andrew Reed</b>		14. MOTHER'S MAIDEN NAME <b>Louise Hollands</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216-10-9163</b>	
17. INFORMANT <b>Mr William R. Reed</b>		Address <b>Box 21 Joppa Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post operative prostatectomy complicated by shock, possible pulmonary embolism and congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>shock, possible pulmonary embolism and congestive heart failure</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 20, 1966</b> , to <b>Nov. 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov. 27, 1966</b> , and that death occurred at <b>10:05 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Juan G. Gan,</b>		22b. DATE SIGNED <b>Nov. 27, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Juan G. Gan, M.D.</b>		22d. ADDRESS <b>7620 York Road, 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>11-30-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Camp Chapel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>
24 FUNERAL DIRECTOR <b>L. S. ...</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 29 1966</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

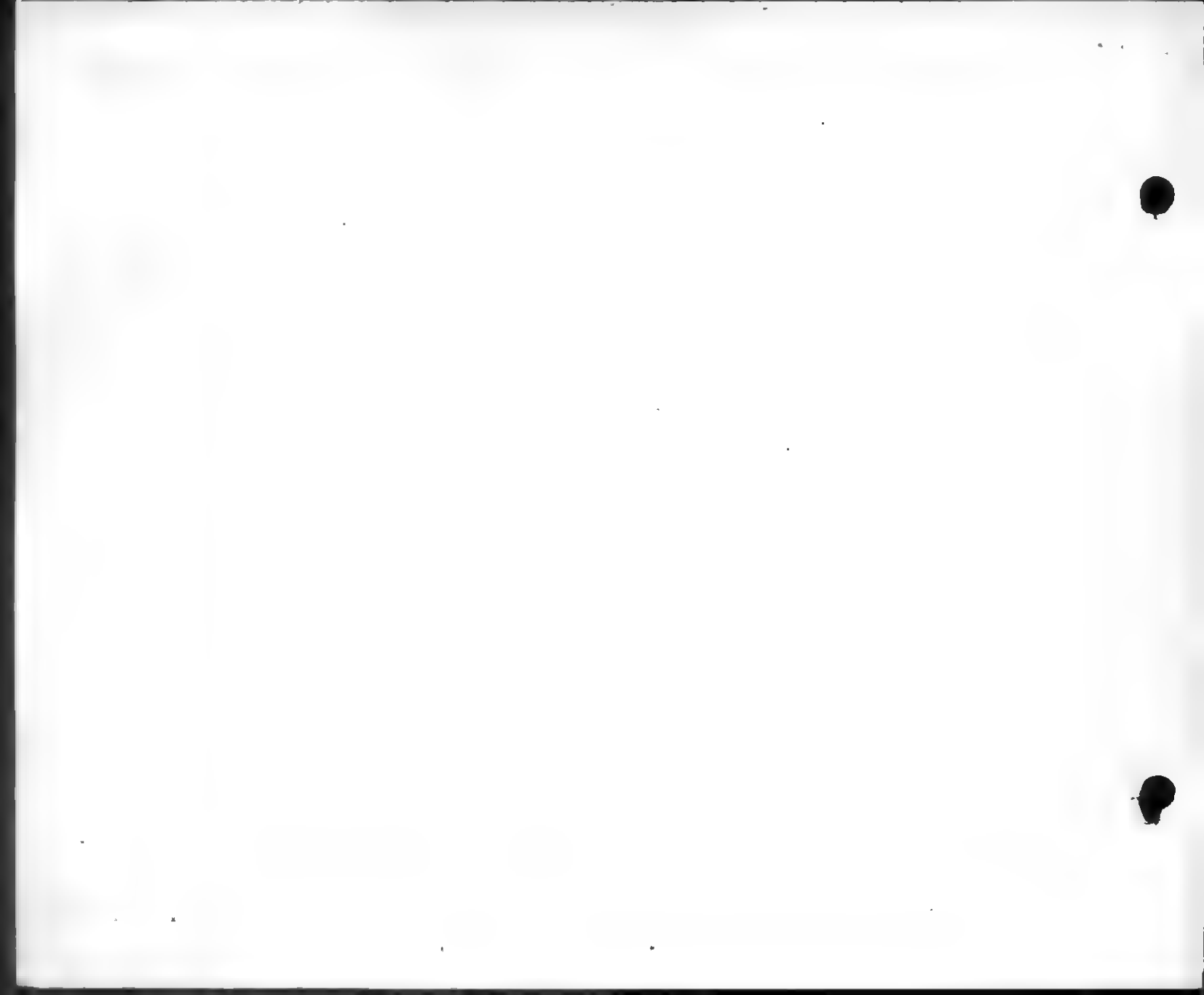
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15362

1 PLACE OF DEATH a COUNTY <i>Balto.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <i>md.</i> b COUNTY <i>Balto.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto 7</i>		c LENGTH OF STAY N 1b <i>4 mo</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8304 Hilmar St.</i>		d STREET ADDRESS <i>8304 Hilmar St</i>	
3 NAME OF DECEASED (Type or print) <i>ELSIE ELIZABETH REED</i>		4 DATE OF DEATH <i>Nov 9 1966</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Feb 22, 1893</i>
9 AGE (In years, lost birth day) <i>73</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Don't Home</i>	11 BIRTHPLACE (State or foreign country) <i>Balto. City.</i>
12 CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Joseph H. Barnes</i>	
14. MOTHER'S MAIDEN NAME <i>Minnie Schrader</i>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <i>no</i>	
16 SOCIAL SECURITY NO <i>217-22-4904</i>		17 INFORMANT <i>Chas. Jrs. Reed, - 8501 Fieldway Drive</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> + <i>kill</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>None</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i> M.D.		22. DATE SIGNED <i>11-9-66</i>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>11/11/66</i>	23c NAME OF CEMETERY OR CREMATORY <i>Parlowood Cemetery</i>	23d LOCATION (City or Town) (County) (State) <i>3310 Taylor Ave. Balt. 21234</i>
24 FUNERAL DIRECTOR <i>Loring Byers-8728 Liberty Rd. Randallstown, Md.</i>		25a REC'D BY REGISTRAR <i>Charles Judge</i> 25b REGISTRAR'S SIGNATURE	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15364 CERTIFICATE OF DEATH 15363

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Cook</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 21204</u>				c. LENGTH OF STAY IN lb <u>5 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>				d. STREET ADDRESS <u>934 Park</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Charles</u> Last <u>Reid</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 6, 1878</u>	
				9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Mln. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>	
13. FATHER'S NAME <u>Thomas Charles</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Blood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>x</u>				16. SOCIAL SECURITY NO. <u>343-38-7030</u>		17. INFORMANT Address <u>Dulaney Towson Nursing Home, 111 West Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>several yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>25 October, 1966</u> , to <u>November 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>29 November 1966</u> , and that death occurred at <u>11</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter T. Kees</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>30 Nov 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>				22d. ADDRESS <u>Cockeysville, Maryland</u> <u>30 Nov 66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd., Balt.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

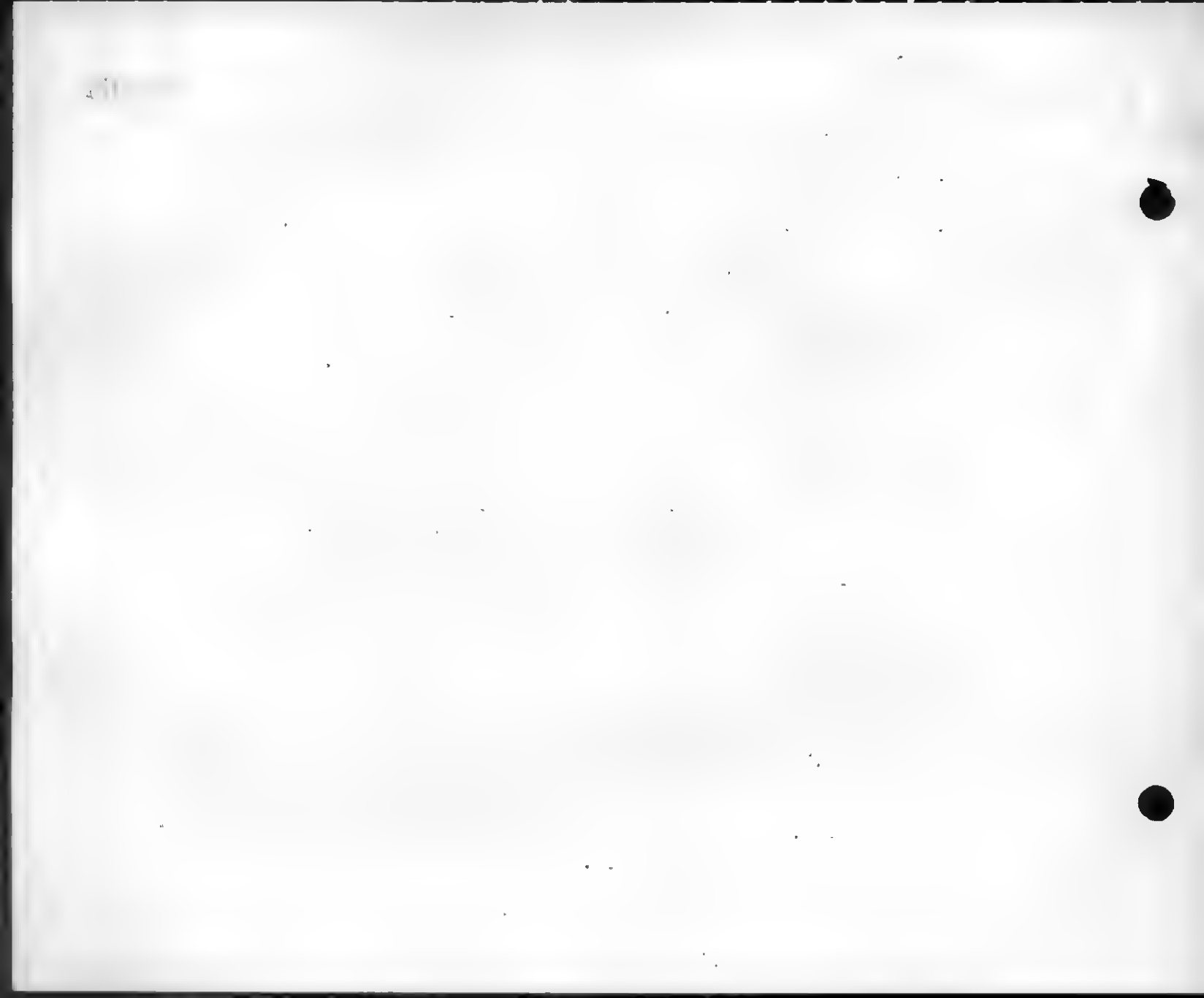
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15365

CERTIFICATE OF DEATH

15364

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>			d. STREET ADDRESS <b>814 Cliffedge Rd. 21208</b>		
3 NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Agnes</b> Last <b>Richards</b>			4. DATE OF DEATH Month <b>11</b> Day <b>25</b> Year <b>1966</b>		
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-94</b>		9. AGE (In years last birthday) yrs <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>	
13 FATHER'S NAME <b>Barnes</b>			14. MOTHER'S MAIDEN NAME <b>Mary Paylan</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>217-54-7728</b>		17. INFORMANT <b>Mrs. Mildred Parks, 814 Cliffedge Rd.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) <b>Myocardial infarction, left ventricle and septum; Thrombosis, right and left coronary arteries; Atherosclerosis, generalized and severe.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <b>W</b> (this hospital) attended the deceased from <b>11-4</b> , 1966, to <b>11-25</b> , 1966, that <b>W</b> (we) last saw the deceased alive on <b>11-25</b> , 1966, and that death occurred at <b>4:40</b> PM, from causes and on the date stated above.					
22a. SIGNATURE <b>Manuel S. Cockburn, M.D.</b>			22b. DATE SIGNED <b>Nov. 26, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Manuel S. Cockburn, M.D.</b>
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE THEREOF <b>Nov. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery, Baltimore, Md.</b>
23d. LOCATION (City or Town) <b>Baltimore, Md.</b>			23e. (County) <b>Baltimore</b>		23f. (State) <b>Md.</b>
24 FUNERAL DIRECTOR <b>Frank H. Newill</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>NOV 30 1966</b>			DATE <b>NOV 30 1966</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

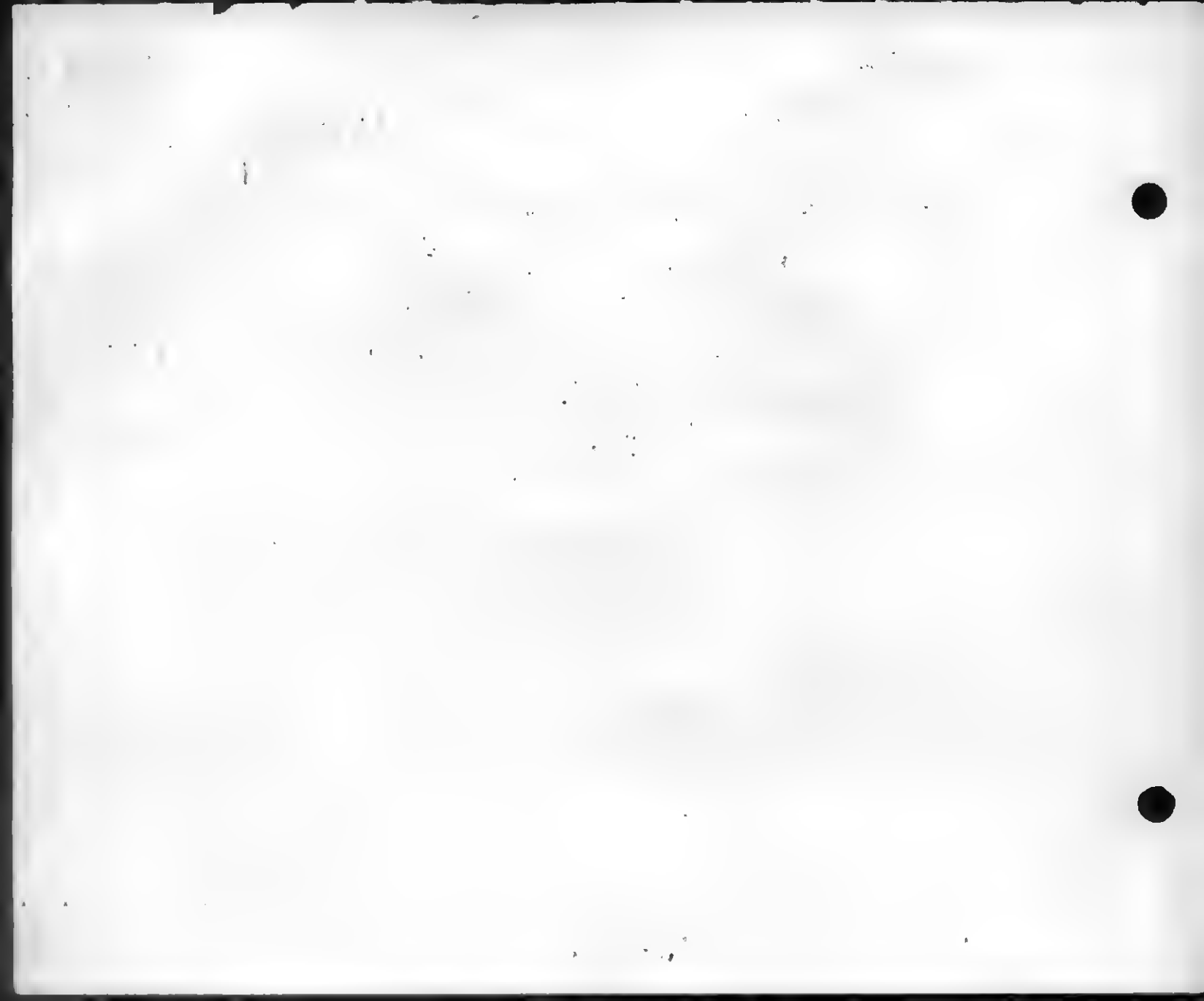
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15366

15365

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson, Maryland 21204</u>			
3. NAME OF DECEASED (Type or print) <u>MATILDA (NMN) Ridgely</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Can</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9, 1923</u> 83 yrs.	
9. AGE (In years last birthday) Months Days Hours Min.				10. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, M.D.</u>			
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>George Henry Baker</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213489181</u>			
17. INFORMANT <u>LOUIS E. KING</u>				Address <u>(SAME)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-Resp. Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Angestive cardiac failure</u> (c) <u>Diabetic Coma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 9, 1966</u> to <u>11th Nov, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 11, 1966</u> , and that death occurred at <u>12:35 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Denis Chan</u>				22b. DATE SIGNED <u>Nov 11 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>				22d. ADDRESS <u>G B M C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/14/1966</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>				23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>				25a. REC'D BY REGISTRAR <u>NOV 14 1966</u>			
Address <u>4905 York Rd. Balto. 12, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



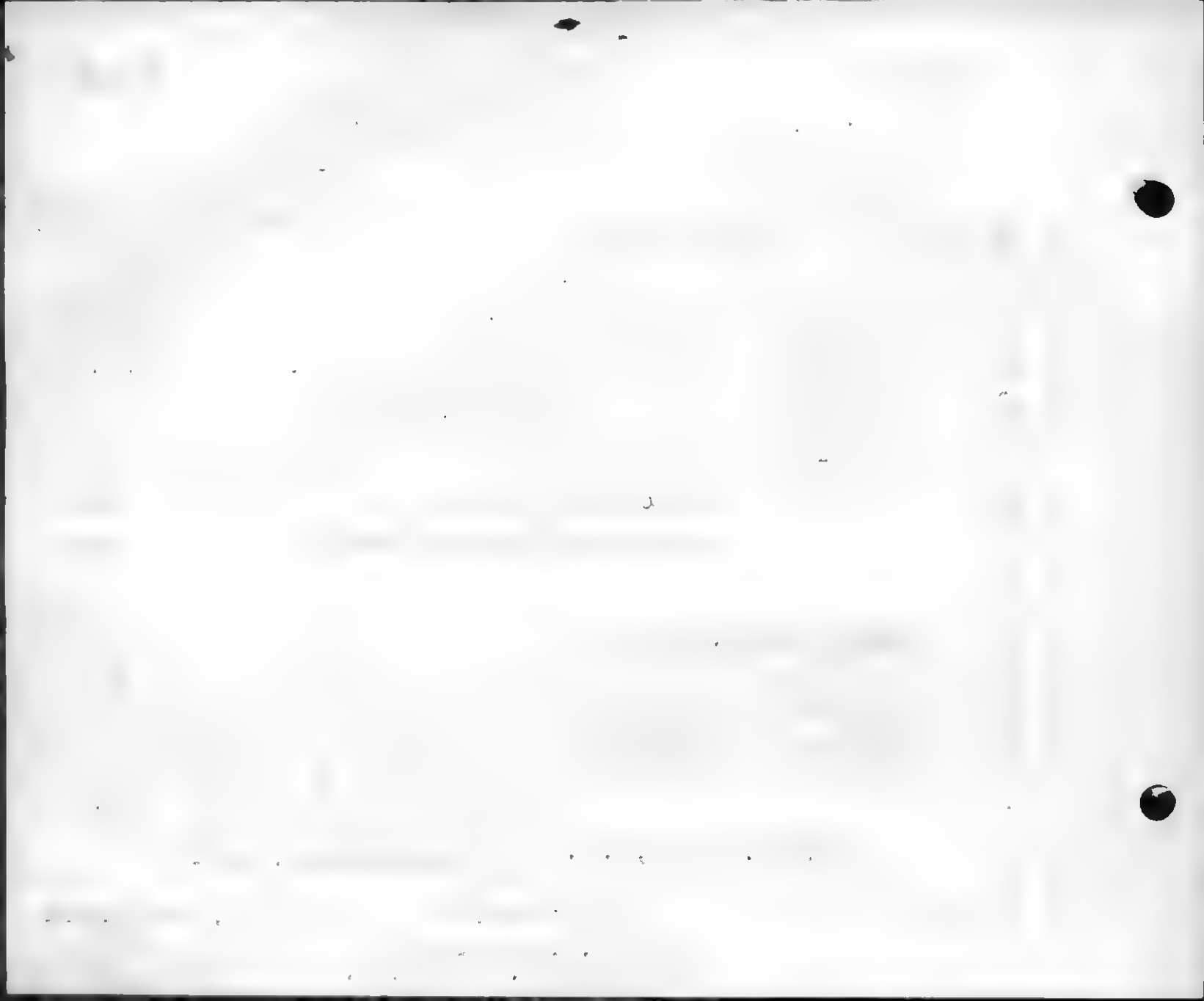
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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SHIPPED TO: STOKES FUNERAL HOME, ROCKY MOUNT, NORTH CAROLINA

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15367					15366				
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY in 1b <b>349 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					d. STREET ADDRESS <b>2620 AISQUITTH STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>OSCAR (NMI) ROBERSON</b>					4. DATE OF DEATH Month Day Year <b>NOVEMBER 2 19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/13/95</b>		9. AGE (In years last birthday) <b>71 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (County & State or foreign country) <b>WILSON COUNTY, N. CAR.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>HOYT ROBERSON</b>					14. MOTHER'S MAIDEN NAME <b>ELLA KNIGHT ROBERSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>			16. SOCIAL SECURITY NO. <b>242 09 72 55</b>		17. INFORMANT <b>VA HOSPITAL, CLINICAL RECORDS, FORT HOWARD, MARYLAND</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____								INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>12 MIN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS, CLINICAL</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>IX</del> (this hospital) attended the deceased from <u>11/18/65</u> , 19 <u>65</u> , to <u>11/2/66</u> , 19 <u>66</u> , that <del>IX</del> (we) last saw the deceased alive on <u>11/2/66</u> , 19 <u>66</u> , and that death occurred at <u>7:50 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>					ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KALMUTZ, M. D.</b>					22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EIM CITY CEMETERY</b>			23d. LOCATION (City or town) (County) (State) <b>EIM CITY, NORTH CAROLINA</b>		
24. FUNERAL DIRECTOR <i>Charles R. Law</i>					25a. RECD BY REGISTRAR <b>1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles R. Law</i>		
ADDRESS <b>CHARLES R. LAW FUNERAL HOME, 302 MADISON AVE. BALTIMORE, MD.</b>									



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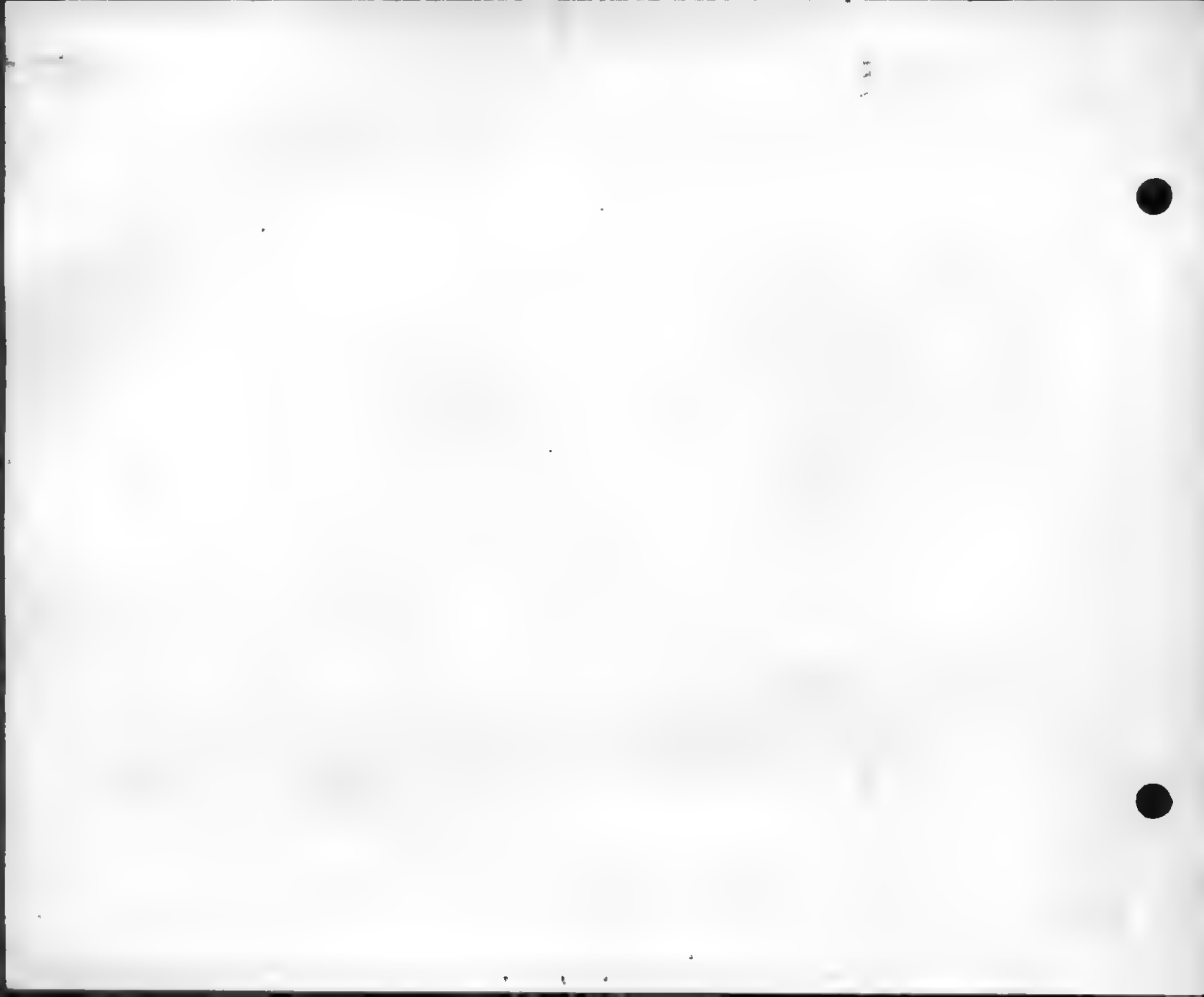
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15368

CERTIFICATE OF DEATH

15367

1 PLACE OF DEATH <b>BALTIMORE</b> a. COUNTY <b>College MANOR Lutherville</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b></b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>		c LENGTH OF STAY IN 1b <b>Baltimore 12</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>COLLEGE MANOR NURSING HOME</b>		d STREET ADDRESS <b>311 E. Lake Ave.</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>ANNA GERMAN ROBERTS</b> first Middle Last		4 DATE OF DEATH <b>11 - 24 1966</b> Month Day Year	
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/1883</b>
9 AGE (In years last birthday) <b>83</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William F. Mathaney</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Melvin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Capt. Howland S. Roberts, 321 Taplow Rd.</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>481X MESENTERIC THROMBOSIS</b> DUE TO (b) <b>DEHYDRATION</b> DUE TO (c) <b>INFLUENZA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b> <b>3 weeks</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>Nov 24, 1966</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Nov 23, 1966</b> and that death occurred at <b>9:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A.S. Chalfant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A.S. CHALFANT</b>		22d. ADDRESS <b>6210 YORK RD. Baltimore 12 Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/26/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**15369**

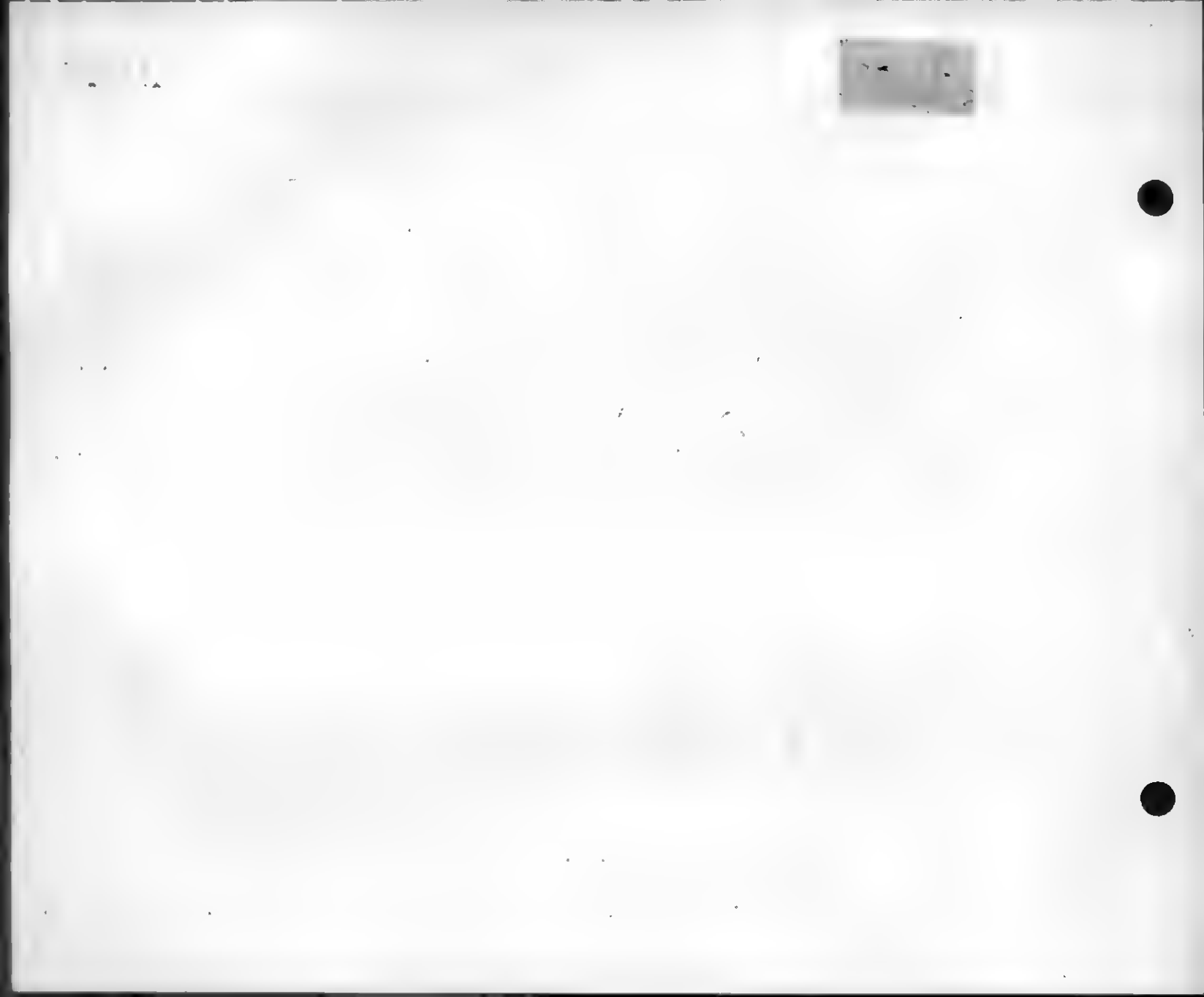
**CERTIFICATE OF DEATH**

**15368**

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21211</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>302 W. LORRAINE AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD G. ROGUSKI</b>				4. DATE OF DEATH Month Day Year <b>11/10/66</b> 19			
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4/28/20</b>	9 AGE (In years last birthday) <b>46 yrs</b>	10 IF UNDER 1 YEAR Months Days Hours Min.		11 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUS DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE TRANSIT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WACLAW ROGUSKI</b>				14. MOTHER'S MAIDEN NAME <b>JOSEPHINE POSWIATOSKA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16 SOCIAL SECURITY NO. <b>214 03 74 72</b>		17. INFORMANT Address <b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GLIABLASTOMA MULTIFORME</b> <b>1931</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>11/8/66</b> , 19 to <b>11/10/66</b> , 19, that (a) (we) last saw the deceased alive on <b>11/10/66</b> 19, and that death occurred at <b>6:25 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KALMUTZ, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>11-14-66</b>		23c NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>DUNDALK AVE. BALTIMORE, MD.</b>	
24 FUNERAL DIRECTOR <b>Wm. Fialkowski</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 14 1966</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15370

## CERTIFICATE OF DEATH

15369

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN TB <u>6 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in the Pines Nursing Home</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>461 Glendale Ave - 21061</u>										
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph A. Rogusky</u>			<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>19</u> Year <u>1966</u>										
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>									
<b>8. DATE OF BIRTH</b> <u>Jan. 5, 1887</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
	Hours												
	Min.												
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>C. G. Co.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lithuania</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>Rogusky</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Victoria Youch</u>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>✓</u>										
<b>17. INFORMANT</b> <u>Dr. Emma Pakala - 461 Glendale Ave - 21061</u>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u> DUE TO (b) <u>A.S.C. w. D. &amp; severe anemia</u> DUE TO (c) <u>Diabetes mellitus</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)									
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>									
<b>21 I certify that (I) (this hospital) attended the deceased from... 1964 to March 9, 1966, that (I) (we) last saw the deceased alive on... 11-9-1966, and that death occurred at 8:00 PM, from the causes and on the date stated above</b>													
<b>22a. SIGNATURE</b> <u>Stanley Ankudis</u>			<b>22b. DATE SIGNED</b> <u>11-9-66</u>										
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>STANLEY ANKUDIS</u>			<b>22d. ADDRESS</b> <u>1101 Maiden Lane</u>										
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/1/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Meadowridge Cem.</u>									
<b>23d. LOCATION</b> (City, town or county) <u>Washington Pk. near</u>		<b>(State)</b> <u>Harvey Md.</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Cowan &amp; Son Inc.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>23. Md.</u>										
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			<b>DATE</b> <u>NOV 10 1966</u>										



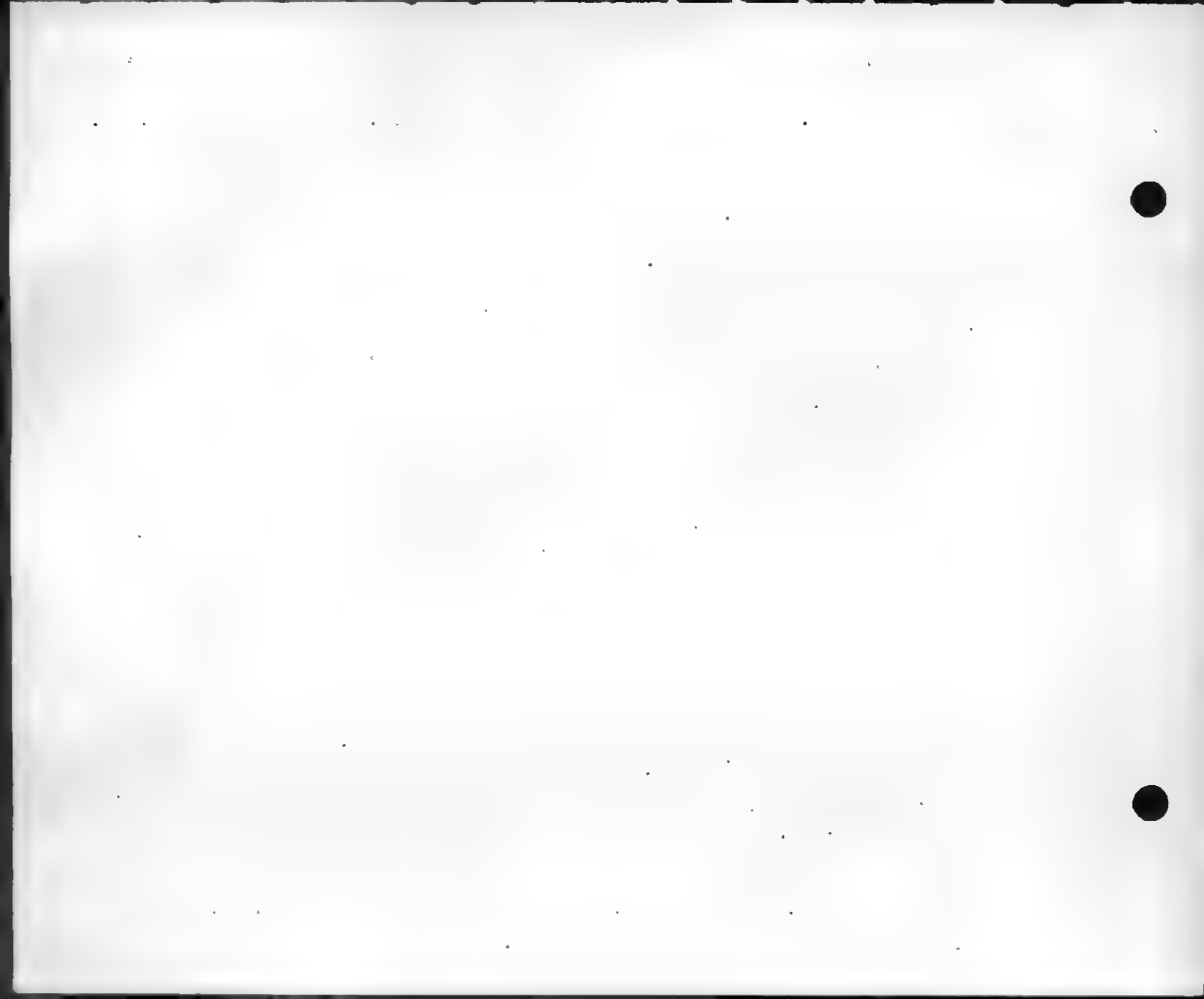
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15371											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5512 Windsor Mill Rd.</u>						d. STREET ADDRESS <u>5512 Windsor Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis R. Rollette</u>						4. DATE OF DEATH <u>Nov. 13, 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15, 1900</u>		9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin L. Rollette</u>						14. MOTHER'S MAIDEN NAME <u>Charollette Lewis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>13 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1953</u> to <u>Nov. 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 7, 1966</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Gilbert E. Rudman</u>						22b. DATE SIGNED <u>Nov. 14 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>GILBERT E. RUDMAN, M.D.</u>						22d. ADDRESS <u>4701 Liberty Hts Ave. Baltimore, Md. 21207</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR <u>G. Truman Schwab</u>						24b. ADDRESS <u>3512 Frederick Ave. Balto. Md/</u>		25a. REC'D BY REGISTRAR <u>NOV 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

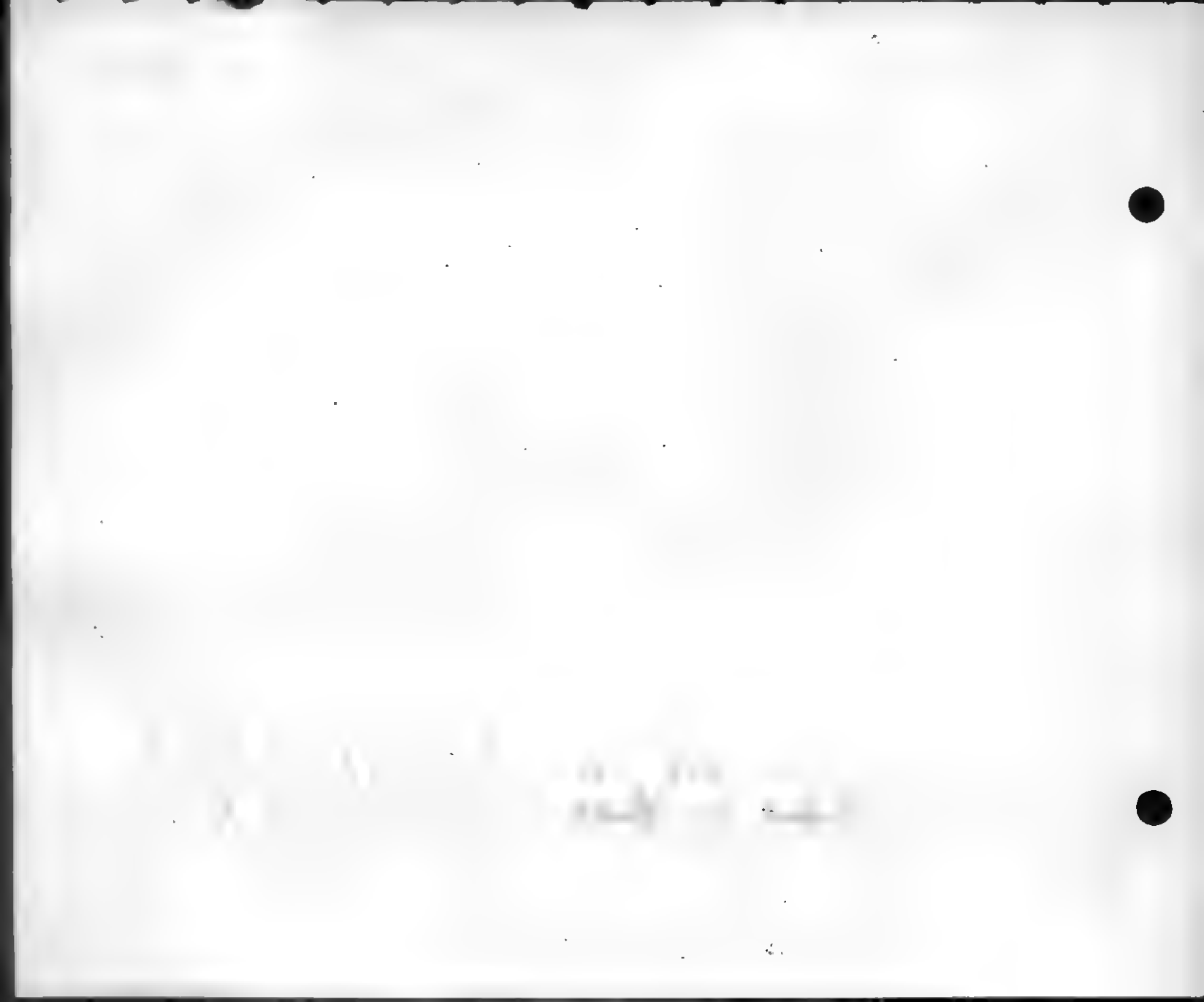


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15372 CERTIFICATE OF DEATH 15371

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE RURAL</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Windsor, Md. RURAL</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>GRACE ETHEL</u> First Middle Last		4. DATE OF DEATH <u>11-4-1966</u> Month Day Year		5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-21-04</u>		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>DANIEL Engler - MARIANNA Royer</u>				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>RALPH ROOP NEW WINDSOR MD</u> Address <u>RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO (b) <u>CARCINOMA OF LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11-2</u> , 19 <u>66</u> , to <u>11-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-4</u> 19 <u>66</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Robert W. Smith</u>												22b. DATE SIGNED <u>11-4-66</u>							
22c. PHYSICIAN'S NAME (Type) <u>R. W. SMITH</u>												22d. ADDRESS <u>G/BMC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11/7/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>				23d. LOCATION (City, town or county) (State) <u>CARROLL CO MD</u>							
24. FUNERAL DIRECTOR <u>DR Hartzler &amp; Sons</u> ADDRESS <u>New Windsor</u>												25a. REC'D BY REGISTRAR <u>NOV 9 1966</u>				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



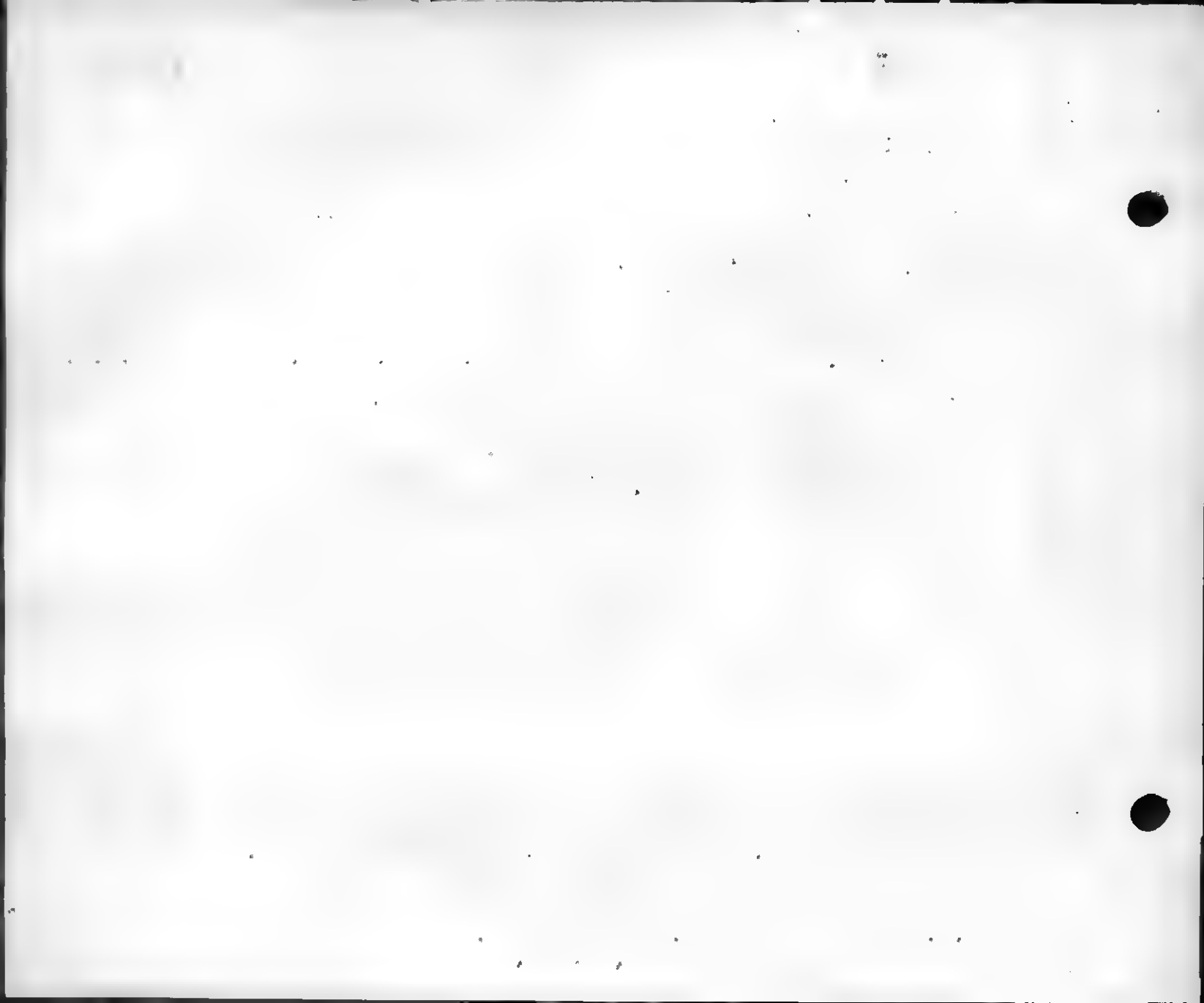


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**15373** **CERTIFICATE OF DEATH** **15372**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jericho Road</b>		d. STREET ADDRESS <b>Jericho Road</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>W.</b> Last <b>Rowe</b>		4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Aberdeen, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Irving Rowe</b>		14. MOTHER'S MAIDEN NAME <b>Lilly Wiles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-32-0257</b>	
17. INFORMANT <b>Mrs. Mary S. Rowe</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1022 (c)</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Healed Tuberculosis Bilateral</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15</b> , 19 <b>65</b> , to <b>Nov. 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov. 22</b> , 19 <b>66</b> , and that death occurred at <b>2A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dudley Phillips</b>		22b. DATE SIGNED <b>11/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. M. Dudley Phillips</b>		22d. ADDRESS <b>Darlington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/28/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>	23d. LOCATION (City, town or county) (State) <b>Abingdon, Harford City, Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

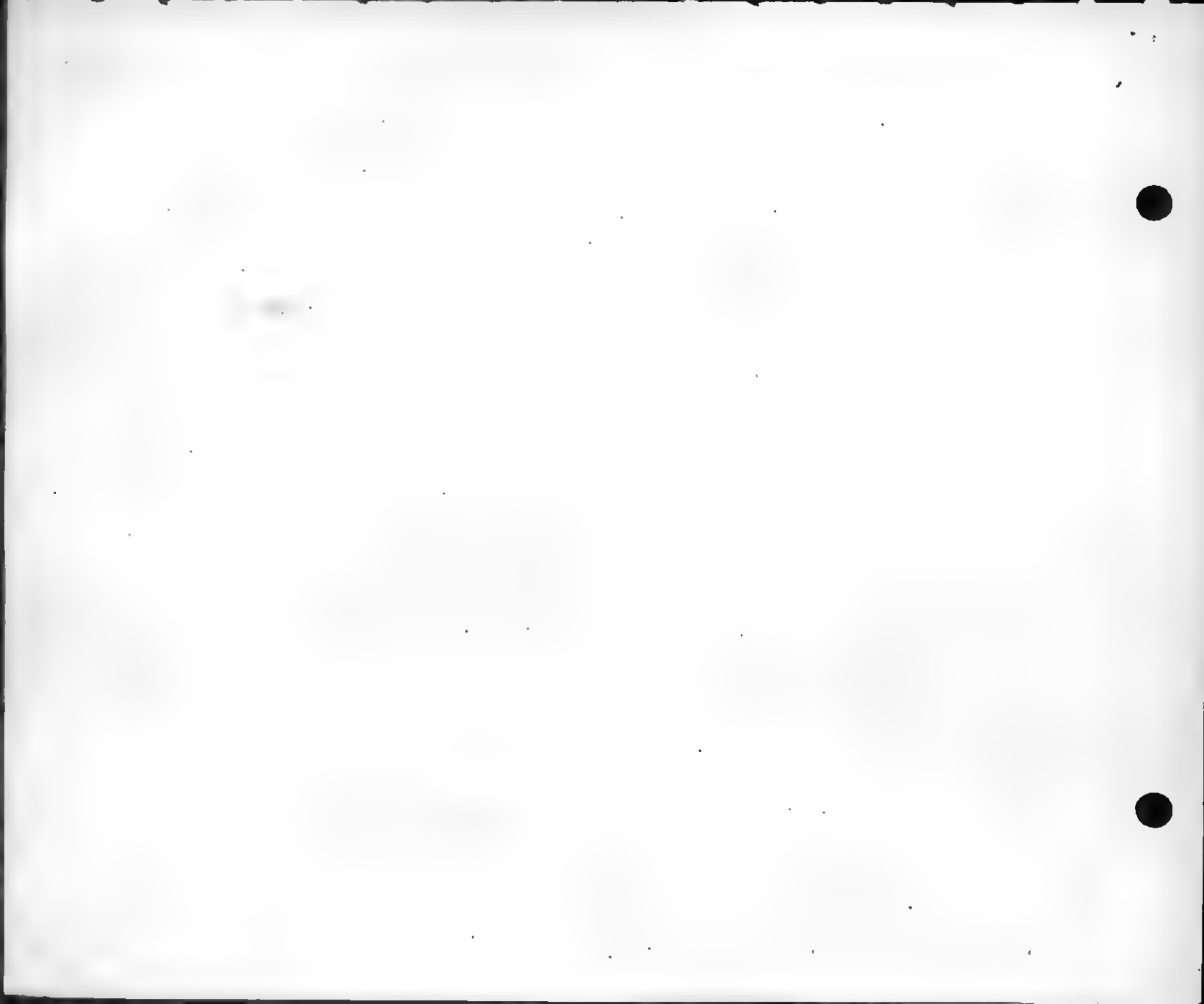


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN ID <u>3 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DULANEY-TOWSON NURSING Home</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3500 Liberty Heights Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marguerite</u> <span style="float: right;">First Middle Last</span> <b>5. SEX</b> <u>F</u> <b>6. COLOR OF RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JAN 1 1897</u> <b>9. AGE</b> (In years last birthday) <u>69</u> yrs. <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months Days Hours Min.			<b>4. DATE OF DEATH</b> <u>Nov. 5<sup>th</sup></u> <span style="float: right;">Month Day Year</span> <u>1966</u>			<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Russia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Jacob B. Barskin</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Esther Glick Barskin</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>215-40-1062</u> <b>17. INFORMANT</b> <u>Mrs. Gable Levy</u> <span style="float: right;">Address</span> <u>2701 Maureen Court #9</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO (b) <u>Hypertension &amp; arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Acute pyelonephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>24 hrs</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 13, 1966</u> <b>to</b> <u>Nov 4, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Nov 3 1966</u> <b>and that death occurred at</b> <u>1215 M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Jonas Cohen</u> <span style="float: right;">M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></span> <b>22b. DATE SIGNED</b> <u>Nov 5, 1966</u>						<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JONAS COHEN</u> <b>22d. ADDRESS</b> <u>6702 PARK HTS. AVENUE</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Nov 6 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hebrew Friendship</u> <b>23d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>				<b>24. FUNERAL DIRECTOR</b> <u>Sal Larson - Bros</u> <span style="float: right;">ADDRESS</span> <u>6010 Reisterstown Rd</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>DATE NOV 9 1966</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15375

CERTIFICATE OF DEATH

15374

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mildred</u> First <u>Rudick</u> Last		4. DATE OF DEATH Month <u>11</u> - Day <u>3</u> - Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last b. day) <u>64</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rabbi Moses Laib Rabinowitz</u>		14. MOTHER'S MAIDEN NAME <u>Esther</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. H. Marnie Rudick, 2607 Taney Road #15</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST + VENTRICULAR FIBRILLATION</u> DUE TO <u>PL. MONARY + MYOCARDIAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PL. MONARY + MYOCARDIAL</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/13/66, 1966</u> to <u>11/3</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>11/3/66, 1966</u> , and that death occurred at <u>9:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Peretz M. Fra</u>		22b. DATE SIGNED <u>11-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. PERETZ M. FRA</u>		22d. ADDRESS <u>BALTL. COUNTY HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/6/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Aitz Chaim</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Solomon &amp; Bros</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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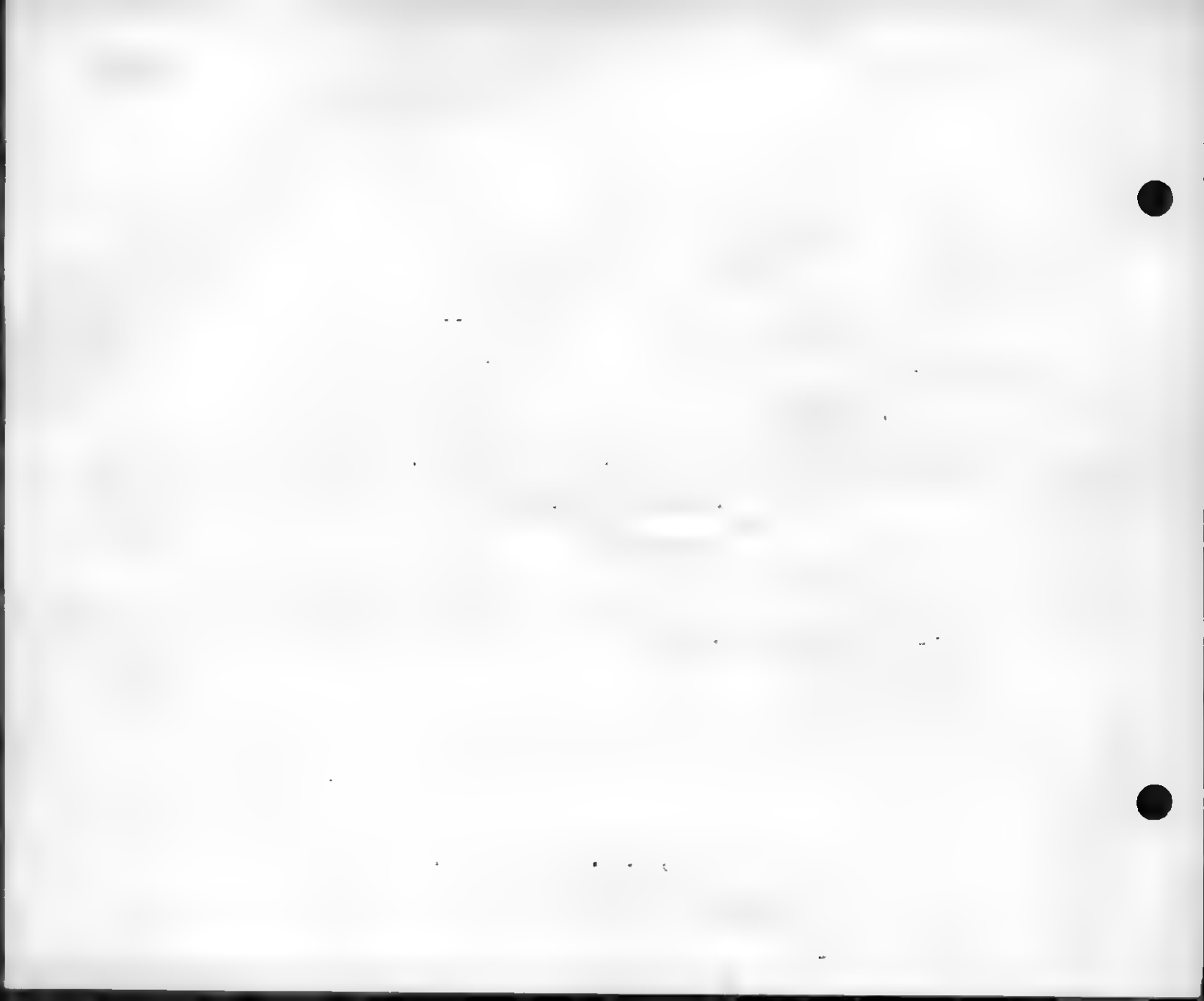
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15376

15375

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>47 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>5323 CUTHBERT AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>DORBERT</b> Last <b>RUDOLPH</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>20</b> Year <b>19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>12 22 09</b>
9 AGE (In years last birthday) <b>56</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBING</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ADAM J. RUDOLPH</b>		14. MOTHER'S MAIDEN NAME <b>MARY STROBLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>225 05 2420</b>	
17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRAIN TUMOR</b> DUE TO (c) <b>60222</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HEALED TUBERCULOSIS, RIGHT LUNG</b>		19 WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT. 4</b> 19 <b>66</b> , to <b>NOV. 20</b> 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>NOV. 20</b> 19 <b>66</b> , and that death occurred at <b>1:10</b> p. M. from causes and on the date stated above			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>11/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/23/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Robert C. Altenburg</i>		25a. REC'D BY REGISTRAR <b>DATE NOV 28 1966</b>	
ADDRESS <b>6009 Harford Rd. Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

15377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15376

1 PLACE OF DEATH a COUNTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>md</u> b COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Cawings Mills Md</u>		c LENGTH OF STAY N 1b <u>24 yrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hosp.</u>		d STREET ADDRESS <u>5405 Highview Ave</u>	
3 NAME OF DECEASED (Type or print) <u>VINCENT ALLEN RUDZINSKI</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX <u>Male</u> 6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B DATE OF BIRTH <u>2-15-'37</u>	
8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 AGE (In years lost birthday) <u>29</u> yrs.	
10a USUAL OCCUPATION (Give kind of work done during most of working life ever followed) <u>Dependent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Vincent Martin Rudzinski</u>		14 MOTHER'S MAIDEN NAME <u>Wally E. Landgraf</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>Rosewood Hosp. Records - Mills</u>		Address <u>Cawings Mills</u>	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>asphyxia due to blood in throat</u> 9217 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>mental retardation</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>24 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Patient grabbed bread &amp; stuffed it in mouth</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>12:15</u> p.m. <u>11-2</u> 19 <u>66</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Wise Cottage</u>		20f (City or town) (County) (State) <u>Cawings Mills Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Notura, causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		22. DATE SIGNED <u>11-2-66</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-5-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue, 21229</u>		25a REC'D BY REGISTRAR DATE <u>NOV 4 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1

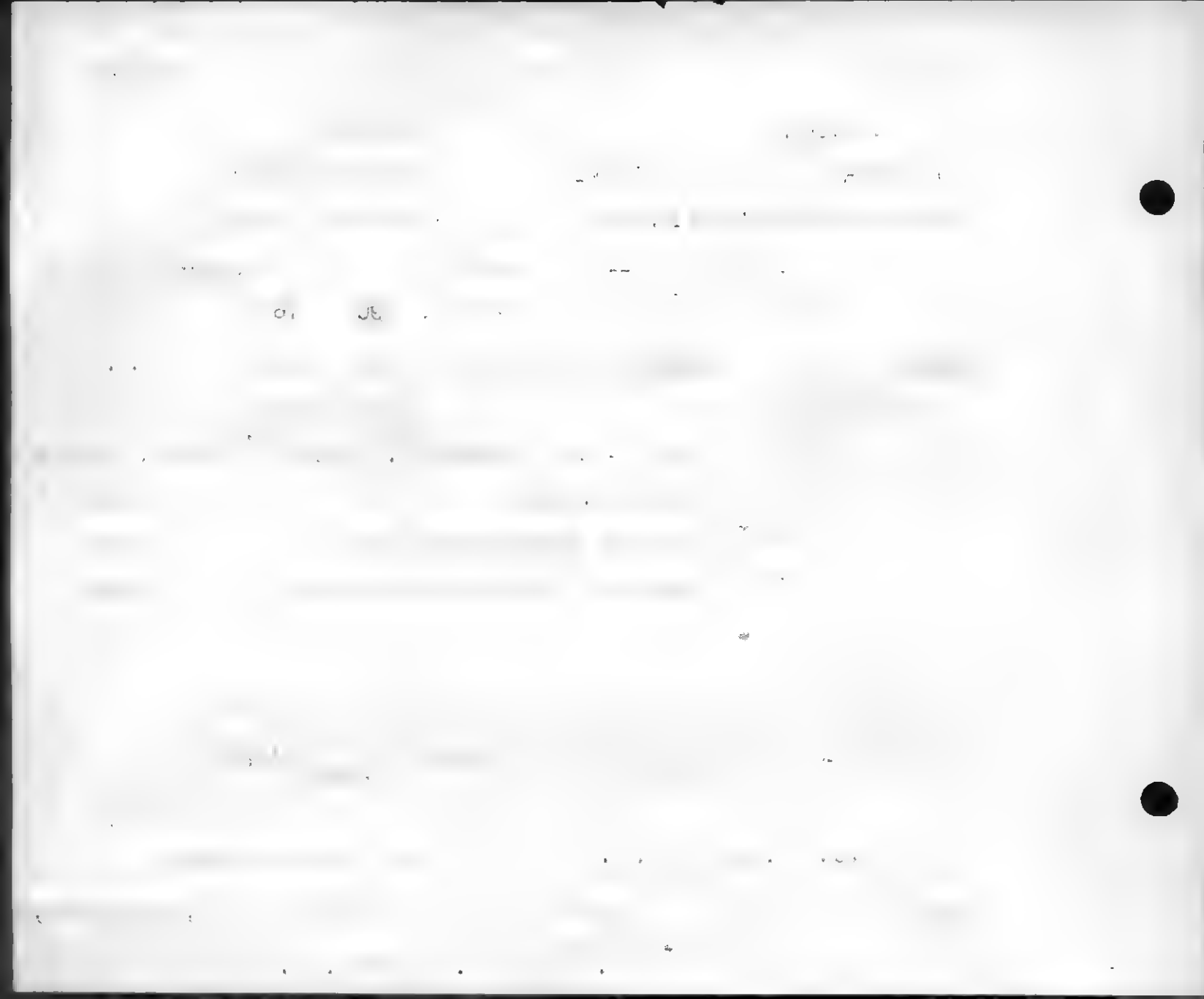
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15378

CERTIFICATE OF DEATH

15377

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>PORT HOWARD</b>		c LENGTH OF STAY IN 1b <b>20 DAYS</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21230</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1033 William Street</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOHN -- SANDERS</b>				4 DATE OF DEATH Month Day Year <b>NOVEMBER 7 19 66</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MARCH 23, 1890</b>	9 AGE (In years last birthday) yrs <b>76</b>	10 IF UNDER 1 YEAR Months Days Hours Min.		11 IF UNDER 24 HRS.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>INSULATOR COMPANY</b>		11 BIRTHPLACE (County & State, or foreign country) <b>ESSEX COUNTY, VIRGINIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>ANDREW SANDERS</b>				14. MOTHER'S MAIDEN NAME <b>LOUELLA ALLEN</b> (Informant: Wife, Lena Sanders, Address - Same - above)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>216 09 26 93</b>		17 INFORMANT <b>CLINICAL RECORDS, VETERANS ADM. HOSPITAL, FT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY CONGESTION AND EDEMA</b> (c) <b>CARCINOMA OF PANCREAS WITH METASTASIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>10/18/66</b> , 19__ to <b>11/7/66</b> , 19__, that (we) last saw the deceased alive on <b>11/7/66</b> , 19__, and that death occurred at <b>7:05 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>				22d ADDRESS <b>VAH PORT HOWARD, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>Fri Nov 11 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>RITCHIE HIGHWAY, GLEN BURNIE, MD</b>	
24. FUNERAL DIRECTOR <i>[Signature]</i>		CURTIS LEVANS <b>21230</b>		25a. RECD BY REGISTRAR <b>NOV 14 1966</b>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Item 2 Film 605 12/1/66 mh

1

15379

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15378

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN TB <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittersville</u> Mt. Wilson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto Co. Gen Hosp</u>				d. STREET ADDRESS <u>Her son's home at Mt. Wilson State Hosp</u>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH SAUER</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/1878</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-44-1591</u>		17. INFORMANT <u>Hospital Records</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>498X</u> IMMEDIATE CAUSE (a) <u>BILATERAL PNEUMONIA</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-10-66</u> , 19 <u>  </u> , to <u>11-27-66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>11-27-66</u> , 19 <u>  </u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Irvin Hyatt</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. IRVIN HYATT</u>				22d. ADDRESS <u>Balto Co. Gen Hospital</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithfield Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pittsburgh Pa</u>	
24. FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Rd Randallstown</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15380

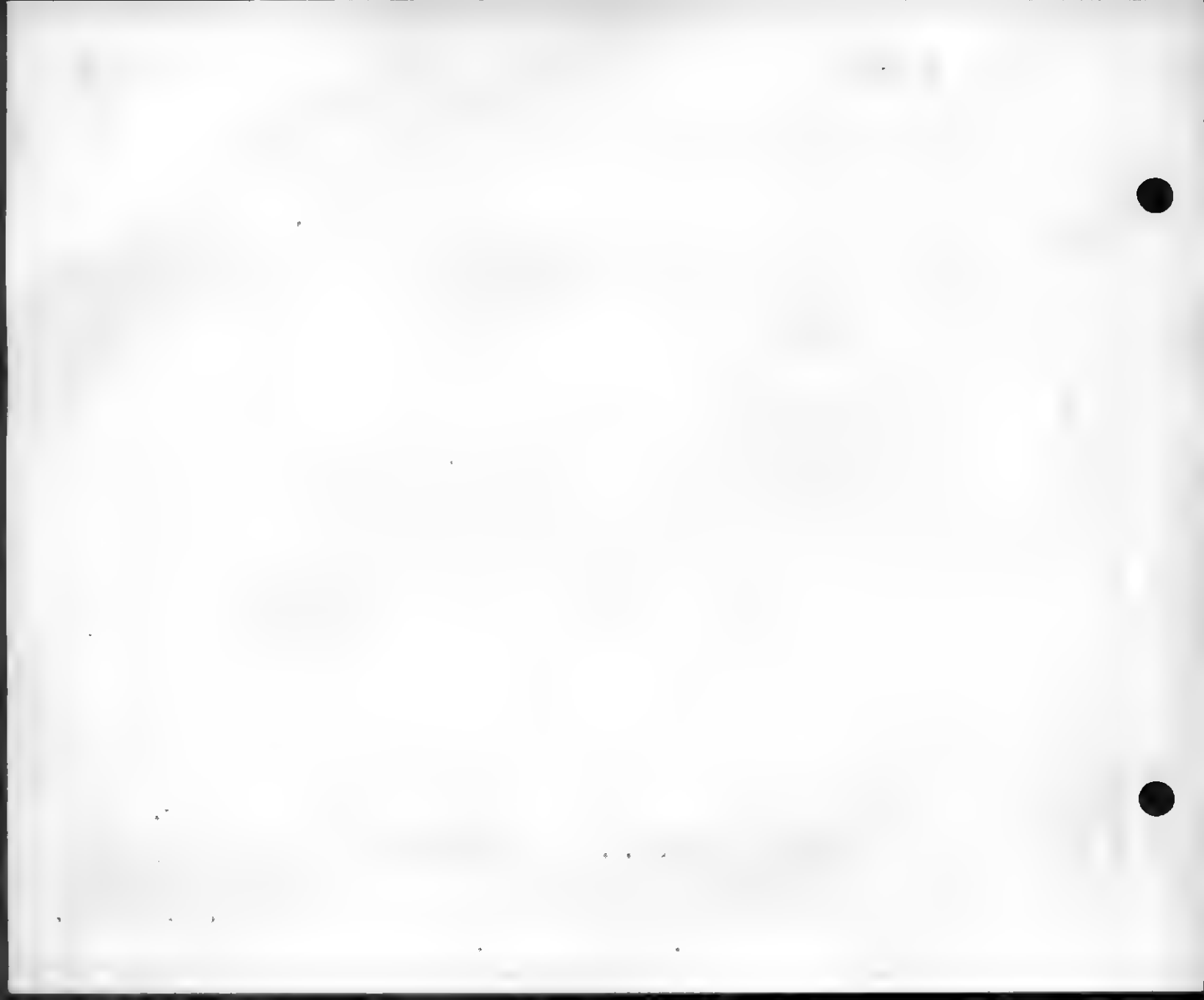
## CERTIFICATE OF DEATH

15379

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>Baltimore 21206</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21206</b> d. STREET ADDRESS <b>5927 Radecke Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Amy Elizabeth Schaefer</b>				4. DATE OF DEATH Month Day Year <b>November 28, 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/28/66</b>	
9. AGE (In years lost birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Mins.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>John Anthony Schaefer, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Larson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>John A. Schaefer (Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/28/</b> , 19 <b>66</b> , to <b>11/28/</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/28/</b> , 19 <b>66</b> , and that death occurred at <b>1:30</b> M, from causes and on the date stated above							
22a. SIGNATURE <i>Lawrence Misanik</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov. 28, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Misanik, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/30/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 30 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15381

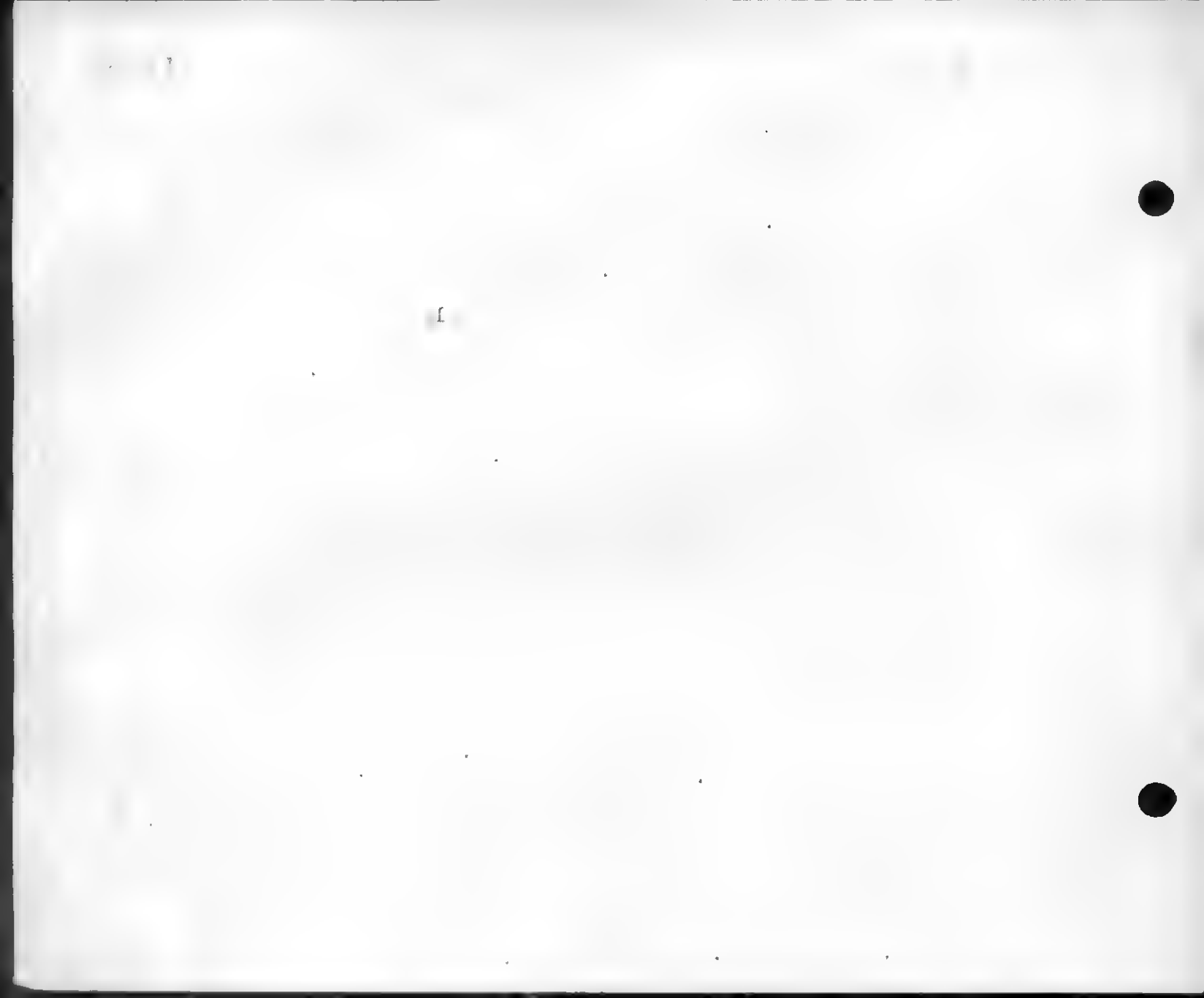
CERTIFICATE OF DEATH

15380

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c LENGTH OF STAY IN 1b <b>21212</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>5733 The Alameda</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Amelia A. SCHILDMAUER</b>		4 DATE OF DEATH Month Day Year <b>Nov. 29 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-1887</b>
9 AGE (In years last birthday) yrs. <b>79</b>		10. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homecraker Sales</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoes</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>William Henry Sanford</b>		14. MOTHER'S MAIDEN NAME <b>Angeline Bradley</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>212093476</b>	
17 INFORMANT <b>Mrs. Kenneth Phelps</b>		Address <b>5733 The Alameda</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis coronary arteries.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus.</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 24, 1966</b> to <b>Nov. 29, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 29, 1966</b> , and that death occurred at <b>5:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>M.S. Cockburn M.D.</b>		22b. DATE SIGNED <b>Nov. 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/2/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>
24. FUNERAL DIRECTOR <b>JOHN F. DENNY, INC. 715 Light St.</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

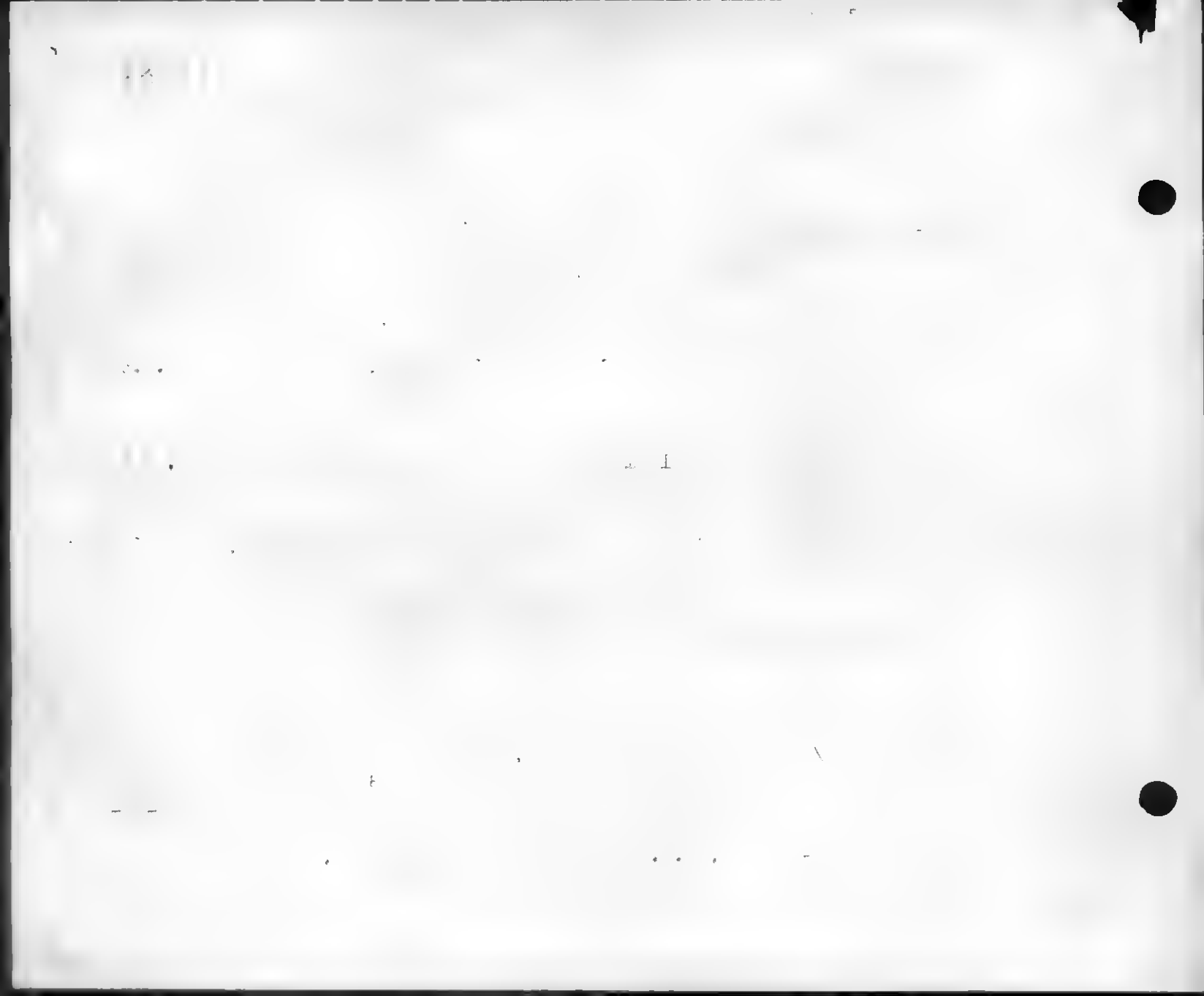
15382

CERTIFICATE OF DEATH

15381

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>135 DA YS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>9114 PHILADELPHIA ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WILLIAM SCHMIDT</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 12 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 25, 1897</b>
9. AGE (In years lost birthday) <b>69 yrs</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>	
11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ADAM SCHMIDT</b>		14. MOTHER'S MAIDEN NAME <b>ANN NEUBAUER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>219 18 53 81</b>	
17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC BRONCHITIS WITH SEVERE EMPHYSEMA.</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 30</b> , 19 <b>66</b> , to <b>NOV 12</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV 12</b> , 19 <b>66</b> , and that death occurred at <b>3:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>ZUI-SUN TAO</b>		22b. DATE SIGNED <b>11-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ZUI-SUN TAO, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Natl.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>J. H. Connelly Sons</b>		25a. REC'D BY REGISTRAR <b>300 More</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>NOV 16 1966</b>	

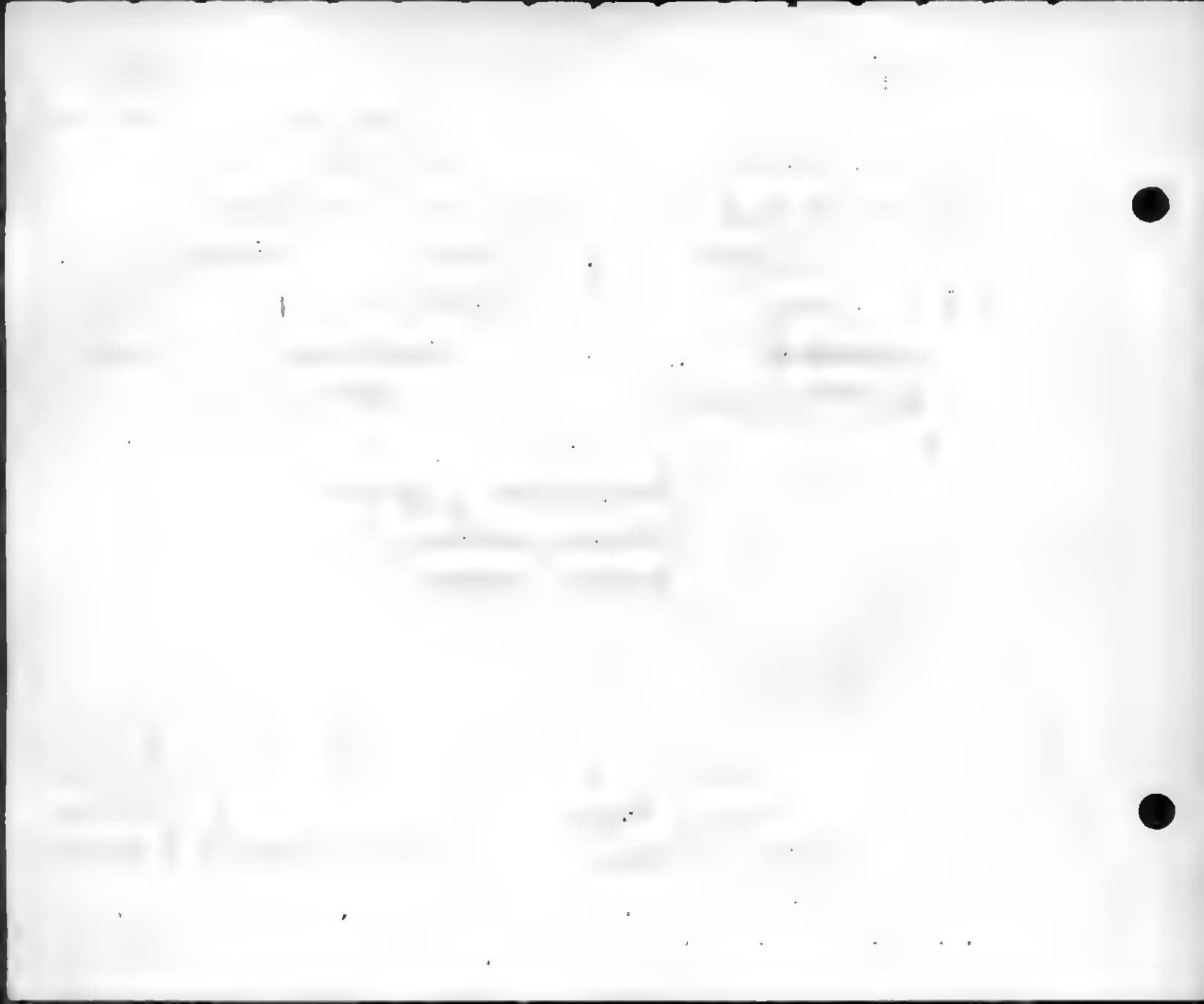
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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<div style="display: flex; justify-content: space-between;"> <span>15383</span> <span>Items 3 &amp; 16 Film G 474 7/2/64 JMJ</span> <span>15382</span> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON BALTIMORE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 18</b> d. STREET ADDRESS <b>3626 ELKADER ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>GLADYS A. or L. A. SCHMIDT</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>November 2 1966</b>					
<b>5. SEX</b> <b>F</b>						<b>6. COLOR OR RACE</b> <b>CAU</b>					
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDDED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>						<b>8. DATE OF BIRTH</b> <b>12/4/1894</b>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPING</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN Home</b>					
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BALTIMORE, MD.</b>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>					
<b>13. FATHER'S NAME</b> <b>MORRIS LAMBDIN</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY KENNEY</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>						<b>16. SOCIAL SECURITY NO.</b> <b>800-70-11076</b>					
<b>17. INFORMANT</b> <b>CARL R. SCHMIDT (SAME)</b>						<b>Address</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Cardio respiratory failure</b> <b>234X</b> <b>DUE TO</b> <b>(b)</b> <b>Pulmonary metastases</b> <b>DUE TO</b> <b>(c)</b> <b>Ovarian neoplasm</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <b>(IF EITHER, NOTIFY MEDICAL EXAMINER)</b>											
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>				<b>(County)</b>				<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11/1</b> , 1966, to <b>11/2</b> , 1966, that (I) (we) last saw the deceased alive on <b>11/2/</b> 1966, and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <b>Juan L. Roque</b>											
<b>22b. DATE SIGNED</b> <b>11/2/66</b>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JUAN L. ROQUE</b>											
<b>22d. ADDRESS</b> <b>6701 N. Charles St. Balto 21204</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>11/5/1966</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. John's Lutheran Ch. Blenheim, Md.</b>			
<b>23d. LOCATION (City, town or county)</b>				<b>(State)</b>							
<b>24. FUNERAL DIRECTOR</b> <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Md.</b>											
<b>25a. REC'D BY REGISTRAR</b> <b>NOV 4 1966</b>											
<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>											



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 3703, 11/28/66 mh

15384

## CERTIFICATE OF DEATH

15383

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bloomsbury Retreat</u>				e STREET ADDRESS <u>200 Bloomsbury Ave.</u> <u>Bloomsbury Retreat</u> <u>Blackery</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Emma</u> Last <u>Schmidt</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>19 66</u>			
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-27-1887</u>	9 AGE (in years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>219543760</u>		17. INFORMANT <u>Henry Schmidt</u> Address <u>8361 Hillendale Rd. 34</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>ESPERANAL UNUSUAL PROFOUND</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CANCER - VASCULAR</u> DUE TO <u>DISSASE</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>66</u> , to <u>11/17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John H. Schaefer</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Schaefer</u>				22d. ADDRESS <u>8361 Hillendale Rd. Baltimore, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>11-21-66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>NOV 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15385

## CERTIFICATE OF DEATH

15384

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u> c. LENGTH OF STAY IN TB _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8233 Pulaski Highway</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____ d. STREET ADDRESS <u>8233 Pulaski Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Barbara Schuler</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>White</u> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> i. DATE OF BIRTH <u>11/7/1900</u> j. AGE (In years last birthday) <u>66</u> yrs. k. IF UNDER 1 YEAR: Months _____ Days _____ l. IF UNDER 24 HRS.: Hours _____ Min. _____ m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home</u> n. KIND OF BUSINESS OR INDUSTRY _____ o. BIRTHPLACE (County & State, or foreign country) _____ p. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		<b>10. FATHER'S NAME</b> <u>Charles Kohler</u> <b>11. MOTHER'S MAIDEN NAME</b> <u>Elinor H. Kohler</u> <b>12. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>13. SOCIAL SECURITY NO</b> _____ <b>14. INFORMANT</b> <u>son - Mr. Charles Schuler</u> Address _____	
<b>15. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> (b) <u>arteriosclerotic Cardio-Vascular disease</u> (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Hypertension</u>		<b>16. INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u> <b>17. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>18. MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY: Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town, County, State) _____		<b>19. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 1</u> 19 <u>66</u> <b>to</b> <u>Nov 12</u> 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Nov 11</u> 19 <u>66</u> , <b>and that death occurred at</b> <u>1 P.M.</u> <b>from the causes and on the date stated above</b> 21a. SIGNATURE <u>A. M. Baumgardner</u> M.D. 21b. PHYSICIAN'S NAME (Type) <u>A. M. Baumgardner</u> 21c. ADDRESS <u>Baltimore</u> 21d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 21e. DATE SIGNED <u>11/14/66</u> 21f. SIGNATURE <u>md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22b. DATE THEREOF <u>11/11/66</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u> 22d. LOCATION (City, town or county) <u>Baltimore</u> (State) _____		23a. REC'D BY REGISTRAR <u>NOV 18 1966</u> 23b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15386 CERTIFICATE OF DEATH 15385

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. Co.</u>			
3. CITY OR TOWN (If outside corporate limits, give full name and live nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>42 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>				e. STREET ADDRESS <u>2511 Eastern Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Wilson</u> Last <u>Seebach</u>				4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/16/06</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>24</u> Min. <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tracer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harry Seebach</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Eber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Charles G. Seebach 109 8th Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic lesion &amp; mediastinal involvement</u> DUE TO (c) <u>Carcinoma of Rt Lung.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>September 19, 1966</u> , to <u>November 1st 1966</u> , that (I) (we) last saw the deceased alive on <u>November, first 19 66</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dora C. Kuwilsky</u>				22b. DATE SIGNED <u>11-1-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dora C. Kuwilsky</u>				22d. ADDRESS <u>Greater Baltimore Medical Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>Geo. L. Schwab FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>NOV 3 1966</u>			

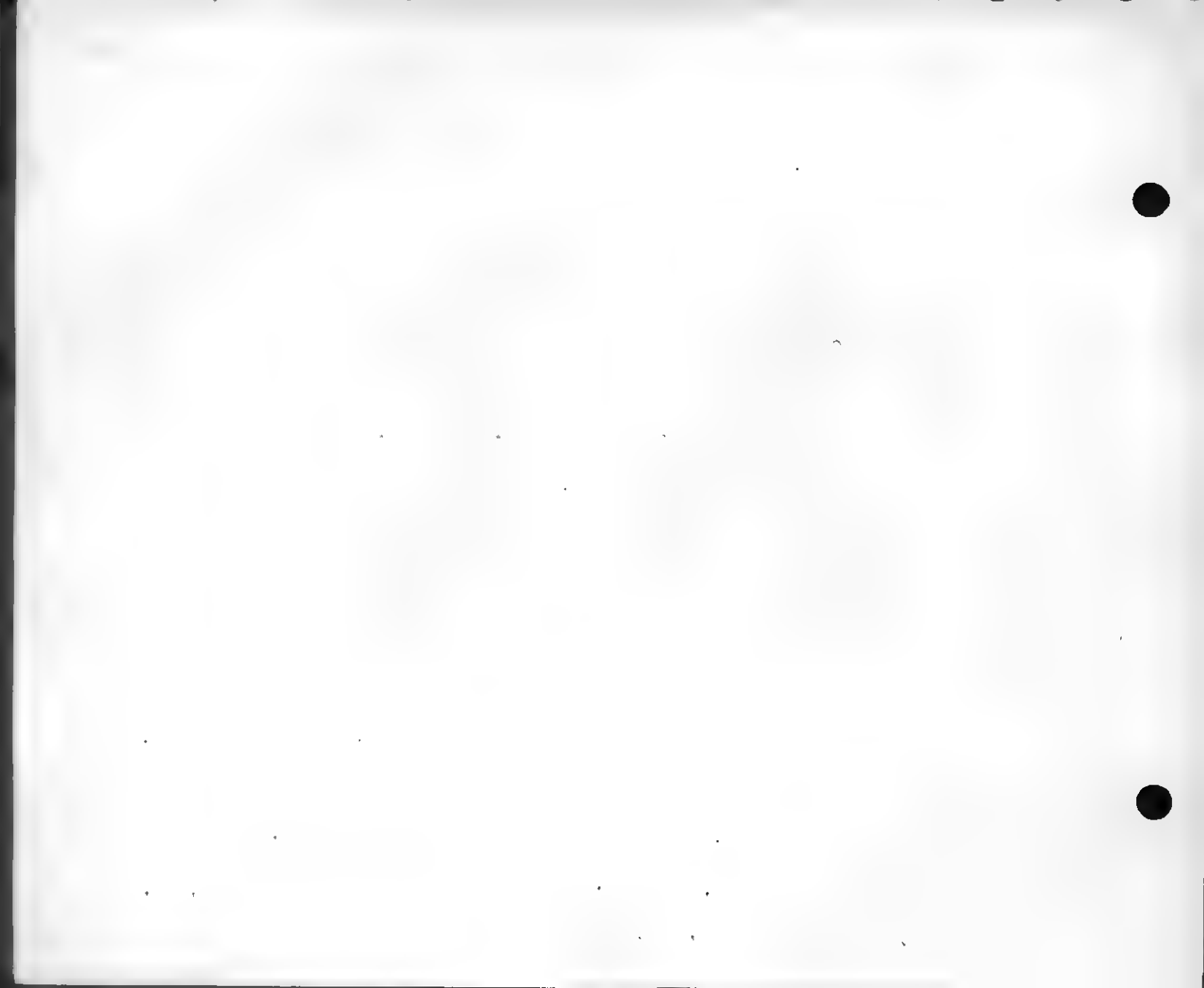


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>15387</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15386</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GBMCC</u>				d. STREET ADDRESS <u>113 Dumbarton Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Melvina</u> Last <u>Selby</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/12/42</u>		9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lealies W. Selby</u>						14. MOTHER'S MAIDEN NAME <u>Sophia E. Selby</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-46-0290</u>		17. INFORMANT <u>Mr. George E. Selby</u>		Address <u>(Same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 17dx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral metastases</u> DUE TO (c) <u>malignant melanoma left eye.</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> , 19 <u>66</u> , to <u>11/27</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Nov. 27</u> , 19 <u>66</u> , and that death occurred at <u>12:52</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W. Smith</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-27-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Smith</u>						22d. ADDRESS <u>G.B.M.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>11/29/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>						ADDRESS <u>Balto. Md.</u>		25. REC'D BY REGISTRAR <u>NOV 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

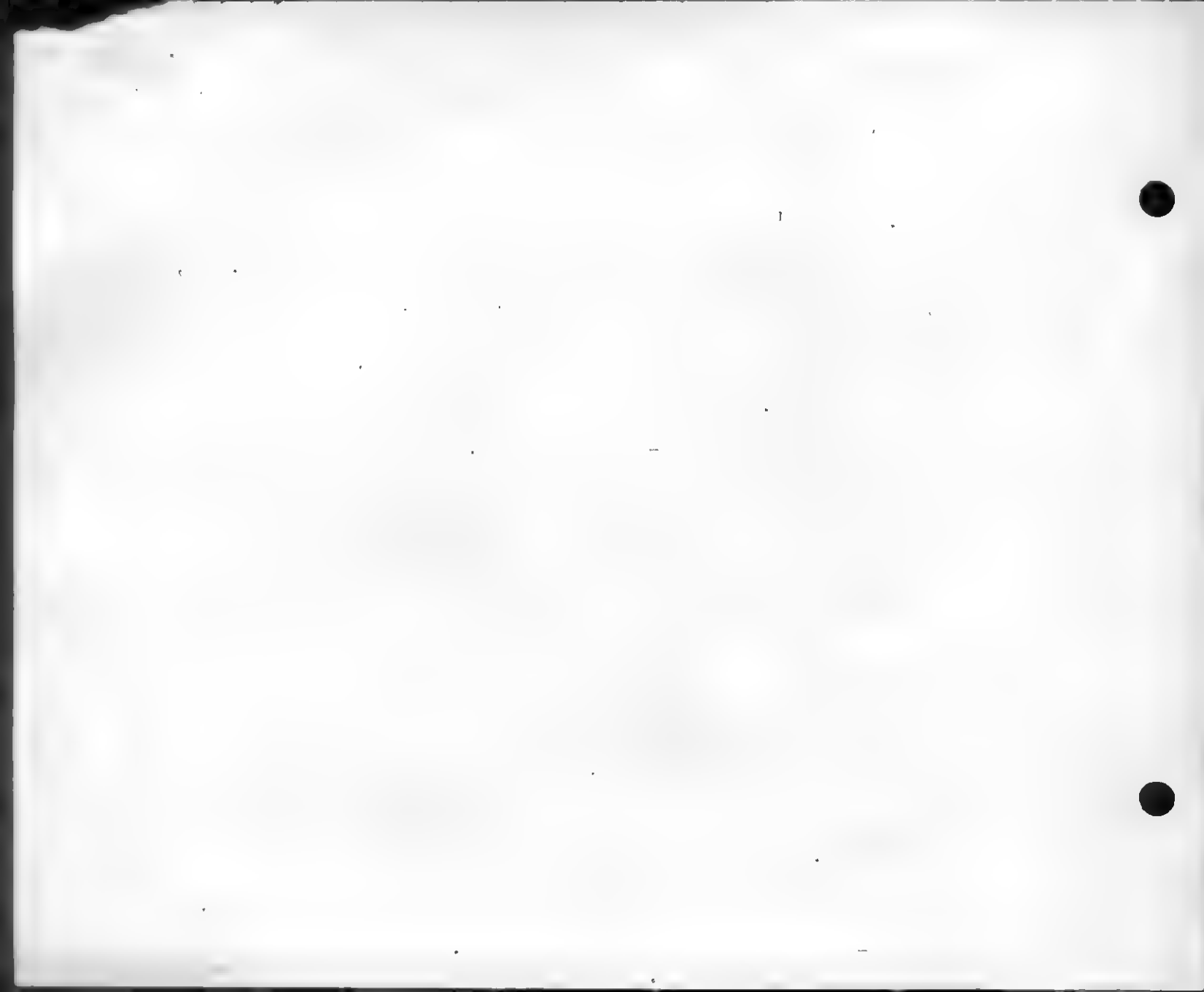
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15388

CERTIFICATE OF DEATH

15387

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>368 Old Trail</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Buckney Stokes Sewell</b>				4. DATE OF DEATH Month Day Year <b>Nov. 11, 1966</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/13/1899</b>		9. AGE (In years or birthday) yrs <b>66</b>	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired letter carrier</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Rock Hall, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Benjamin F. Sewell</b>				14. MOTHER'S MAIDEN NAME <b>Anna Kerr</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>213-38-8565</b>		17. INFORMANT <b>Mrs. Alma Sewell</b> Address <b>368 Old Trail</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 3, 1966</b> to <b>Nov 11, 1966</b> that (I) (we) last saw the deceased alive on <b>Nov 11, 1966</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>William H. Fusting</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William Fusting</b>				22d. ADDRESS <b>4230 Loch Raven Blvd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 15 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
Baltimore, Maryland 21212							





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

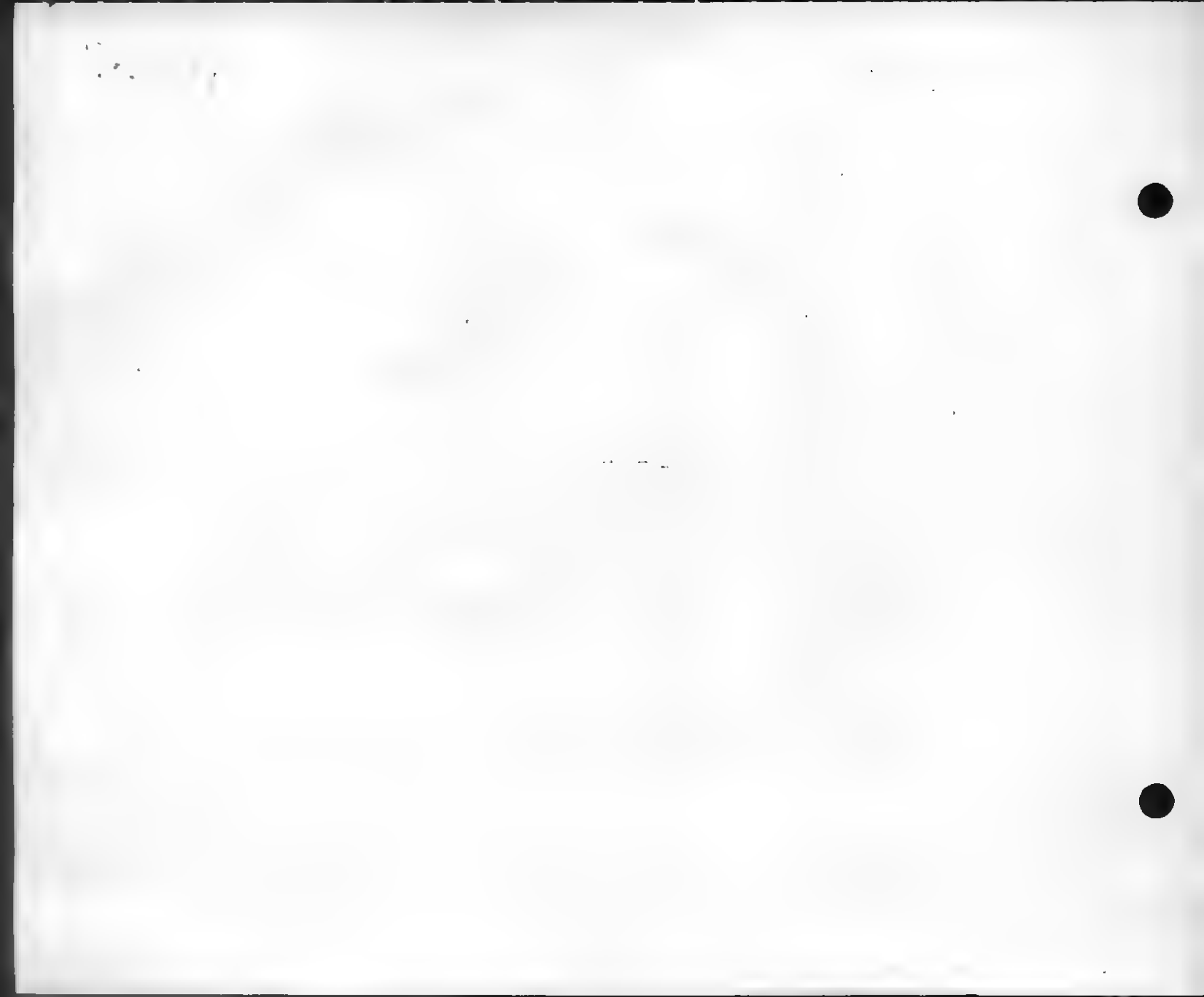
15389

15388

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN lb <b>1yr5mth18dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>5119 Ardmore Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roscoe Conklin Shipley</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1965</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1878</b>		9. AGE (In years last birthday) yrs <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Photo Engraver-News American</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Benjamin Shipley</b>				14. MOTHER'S MAIDEN NAME <b>unknown Henrietta Oles</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>212-03-0372</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4200 Congestive Heart Failure -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease -</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>May 14</b> , 19 <b>65</b> to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>7:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Narciso W. Carmona</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>NARCISO W. CARMONA</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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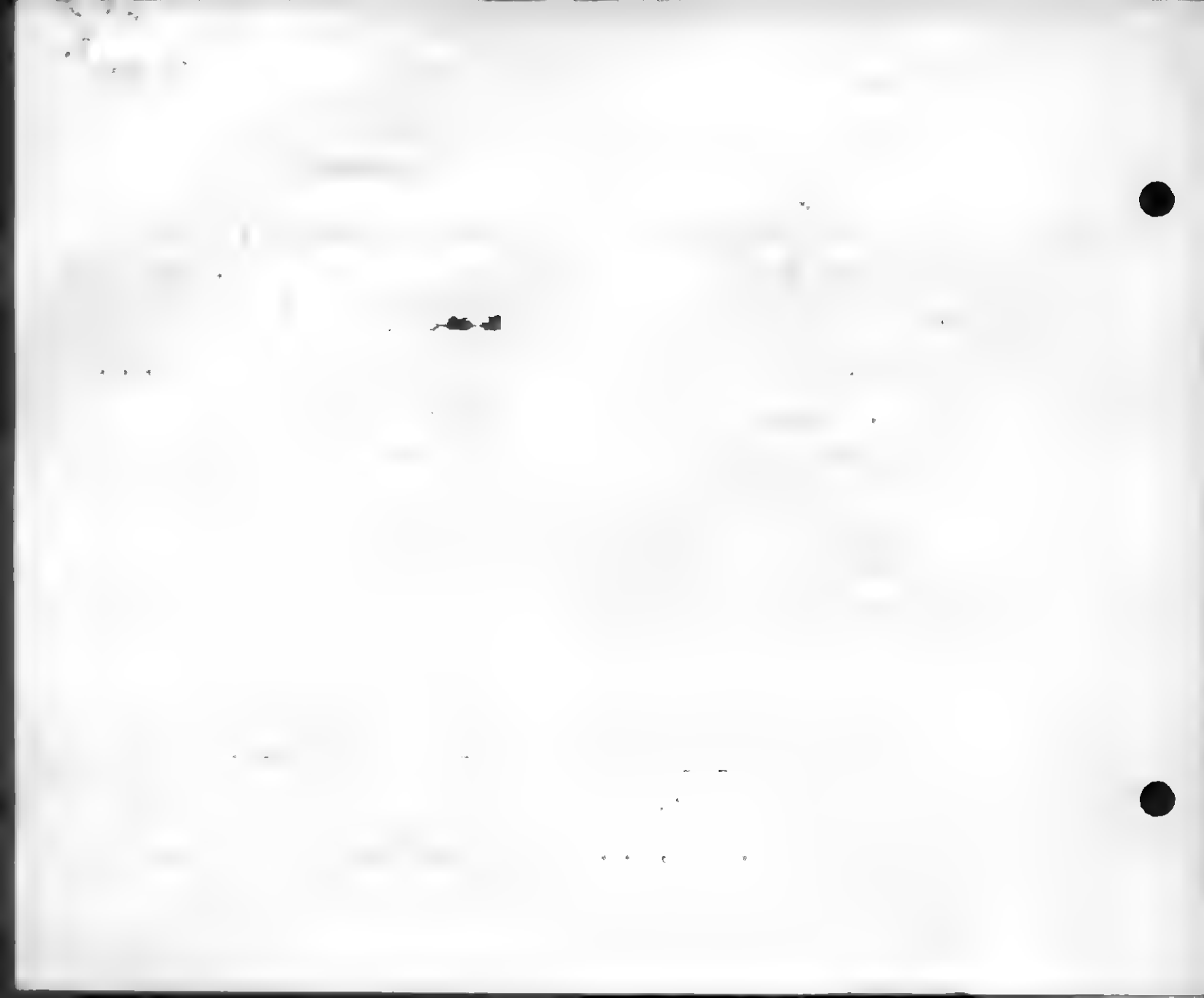
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15390

15389

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 28</b>		c. LENGTH OF STAY IN 1b <b>34 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>Wado Avenue, Baltimore - 28</b>	
3 NAME OF DECEASED (Type or print) <b>HARRY SHRIVER</b>		4. DATE OF DEATH <b>Nov. 21 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 15 1893</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal miner</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Ftostburg, Md</b>	
13. FATHER'S NAME <b>Walter W. Shriver</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Eisel</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv etc) <b>yes World War I</b>		16 SOCIAL SECURITY NO.	
17. INFORMANT <b>Martin Kircher</b>		Address <b>1215 Fidelity Bldg Balto 1 Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Atherosclerotic Heart Disease</b> (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-12-1932</b> to <b>11-21-1966</b> that (I) (we) last saw the deceased alive on <b>11-24-1966</b> , and that death occurred at <b>10:40 P.M.</b> from causes and on the date stated above			
22a SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>11-25-66</b>	
22c PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d ADDRESS <b>Spring Grove State Hospital</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 29 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		23d LOCATION (City or town) (County) (State) <b>Frederick Road Md</b>	
24. FUNERAL DIRECTOR <b>The Dippel Bros Inc</b>		25a REC'D BY REGISTRAR <b>NOV 28 1966</b>	
ADDRESS <b>7110 Belair Road</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15391

## CERTIFICATE OF DEATH

15390

1. PLACE OF DEATH a. COUNTY <u>Bald</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u> c. LENGTH OF STAY IN 1b <u>Chase Md</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Graces St. Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>2</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase Md</u> d. STREET ADDRESS <u>Graces St. Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Crestley A Shutt</u> First Middle Last 4. DATE OF DEATH <u>Nov 4</u> 19 <u>66</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Decorator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTH PLACE (County & State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>Same</u>				13. FATHER'S NAME <u>Chas A Shutt</u> 14. MOTHER'S MAIDEN NAME <u>Seward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY NO. <u>214-12-2980</u> 17. INFORMANT <u>Mrs Kaiser</u> Address <u>Same</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>66</u> , to <u>11/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/4</u> , 19 <u>66</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>M. Castro, Jr.</u> 22b. DATE SIGNED <u>11/4/66</u> 22c. PHYSICIAN'S NAME (Type) <u>M. CASTRO, Jr., M.D.</u> 22d. ADDRESS <u>805 Truslage Ave., Baltimore, Md.</u>			
23a. JUDICIAL CREMATION <input type="checkbox"/> REMOVAL (Specify) 23b. DATE THEREOF <u>Nov 7 66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u> 23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>				24. FUNERAL DIRECTOR <u>GA Steemann</u> ADDRESS <u>6067 Harford Rd</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>NOV 10 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MD  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15392

CERTIFICATE OF DEATH

15391

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (FREELAND)</u>		c. LENGTH OF STAY IN 1b <u>3 YEAR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MiddleTown Rd Freeland Md</u>		d. STREET ADDRESS <u>MiddleTown Rd</u>	
3. NAME OF DECEASED (Type or print) <u>ESTHER NATALY SINDALL</u>		4. DATE OF DEATH <u>Nov 15 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Joseph F SINDALL</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE DAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph D SINDALL</u>		Address <u>5939 Benton Heights</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>A.I.C.V. disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/64</u> , 19____ to <u>11/15/66</u> , 19____, that (I) (we) last saw the deceased alive on <u>11/14</u> , 19 <u>66</u> , and that death occurred at <u>10:15</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/15/66</u>
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-18-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORELAND Memorial</u>	23d. LOCATION (City or town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>CHARLES F EVANS &amp; SON</u>		ADDRESS <u>8802 Hartford Rd</u>	25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

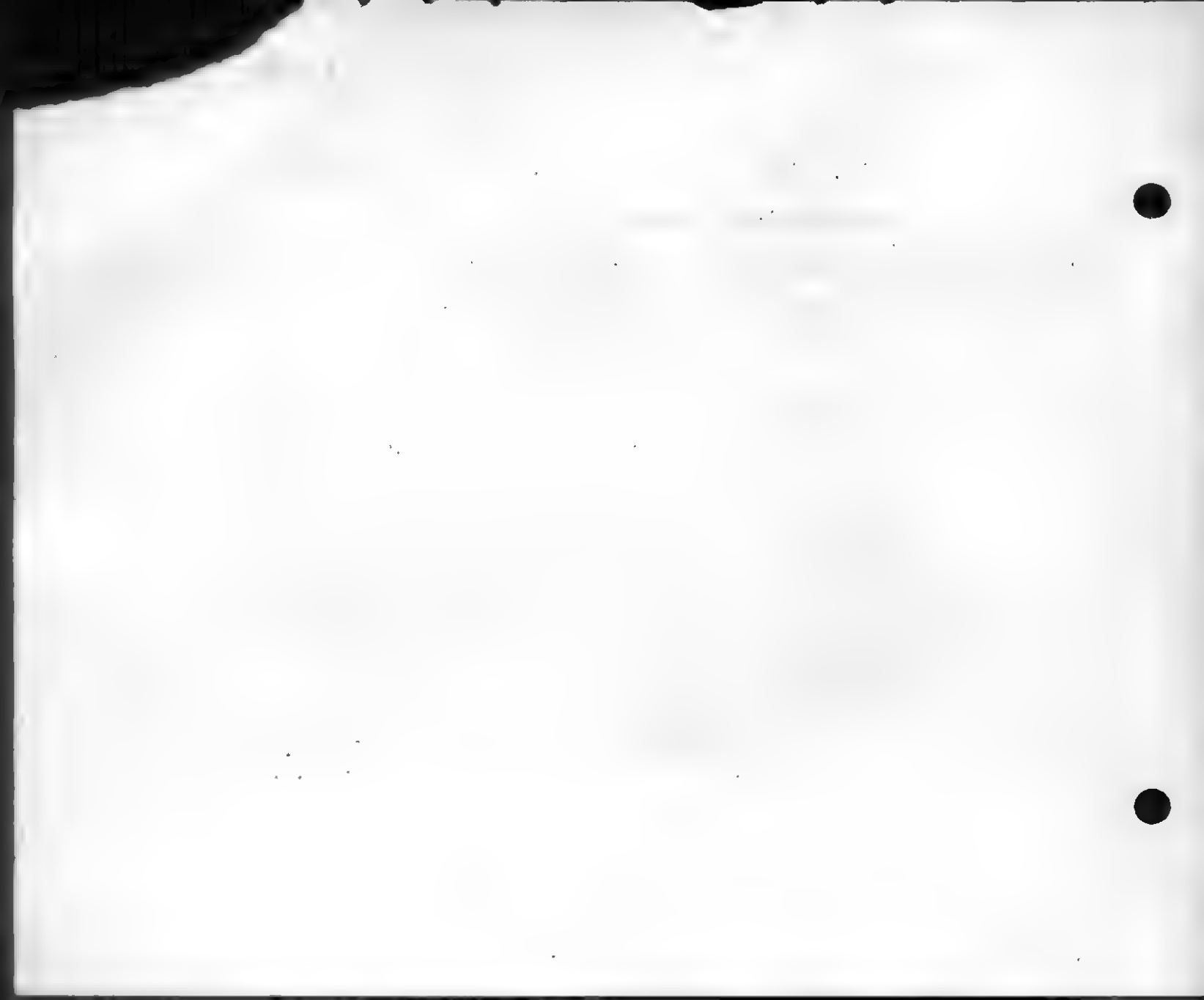
1771



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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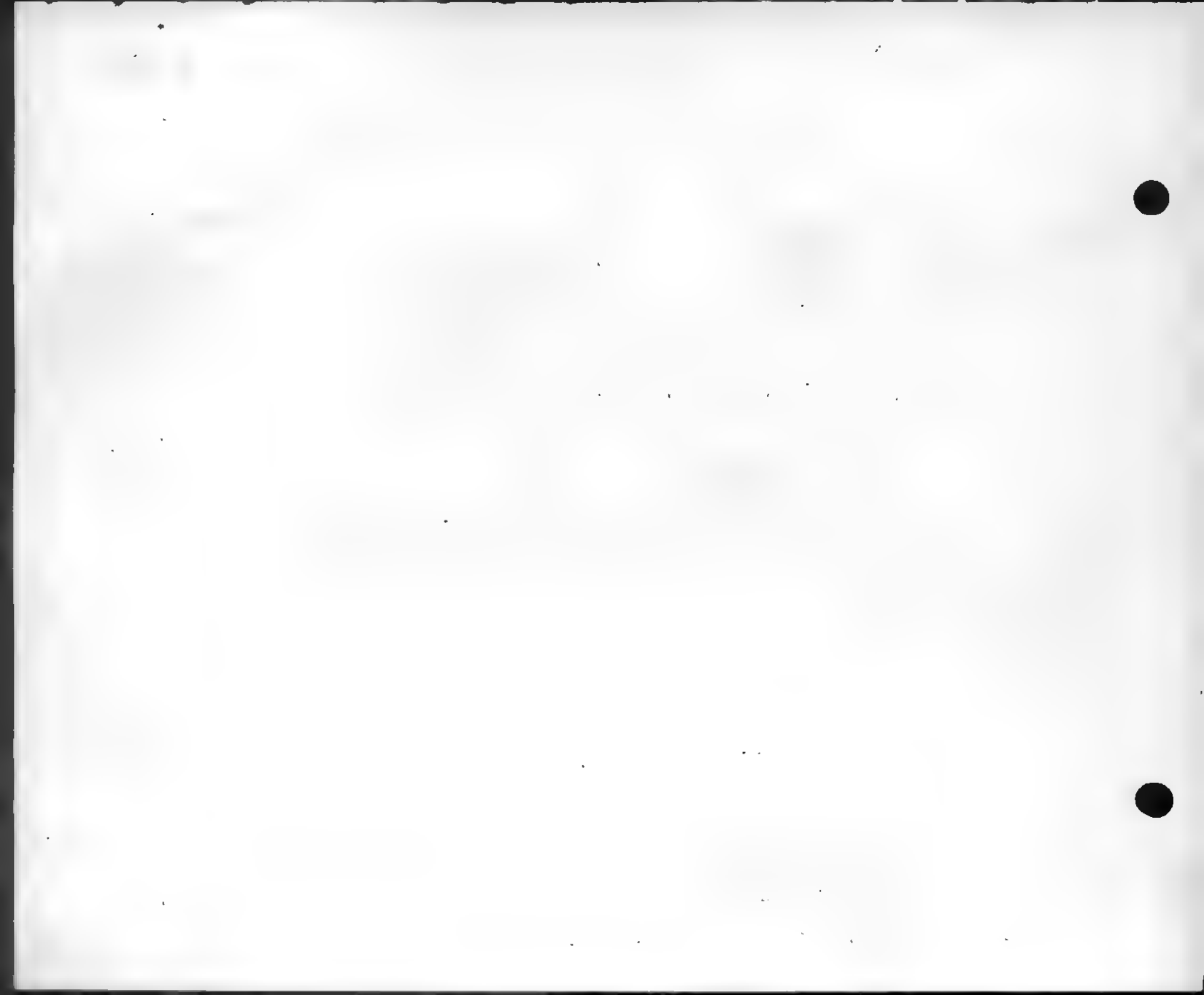
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE											
<div style="display: flex; justify-content: space-between;"> <span>15393</span> <span>CERTIFICATE OF DEATH</span> <span>15392</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN ID <b>3 1/2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b> d. STREET ADDRESS <b>3315 Mayfair Road</b>					
3. NAME OF DECEASED (Type or print) <b>John Thomas SIMPSON</b>			4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>19 66</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>9-22-60</b>			9. AGE (in years last birthday) <b>6</b> yrs.			10. IF UNDER 1 YEAR (FUNDER 24 HRS. Months Days Hours Min.)		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>			11b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Donald Joseph Simpson</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Lucille Willis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>---</b>			17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 4 inx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ehler-Danlos syndrome</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from <b>12-11</b> , 19 <b>62</b> , to <b>11-21</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>11-21</b> , 19 <b>66</b> , and that death occurred at <b>11:30</b> from the causes and on the date stated above. 22a. SIGNATURE <b>[Signature]</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b> 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/25/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Family</b> 23d. LOCATION (City, town or county) (State) <b>Randallstown, Md.</b> 24. FUNERAL DIRECTOR <b>Harry D. Armocost</b> ADDRESS <b>4204 Ridgewood Baltimore 21215</b> 25a. REC'D BY REGISTRAR <b>[Signature]</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> DATE <b>Nov. 25 66</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
15394				CERTIFICATE OF DEATH				15393					
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>1 yr - 8 mos</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DULANEY-TOWSON NRSg. HOME</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>8402 Greenway</b> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO									
3. NAME OF DECEASED (Type or print) <b>GENEVIEVE L. SMALLWOOD</b>				4. DATE OF DEATH <b>11 28 1966</b>									
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-13-80</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN L. O'Neal</b>				14. MOTHER'S MAIDEN NAME <b>Dorcus H. Hammontree</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>216467014T</b>				17. INFORMANT <b>William H. Smallwood</b>				Address <b>1523 Northgate</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Myocardial failure</b> 4201 DUE TO (b) <b>Arteriosclerotic CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Gastro Enteritis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 17, 1966</b> , to <b>Nov 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 17, 1966</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Joseph F. Li Pira</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>11/28/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH F. LIPIRA</b>				M.D. ADDRESS <b>8400 Loch Raven Blvd. Balt. 4, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>12-1-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>				ADDRESS <b>Baltimore, Md.</b>				25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
				DATE <b>NOV 30 1966</b>									

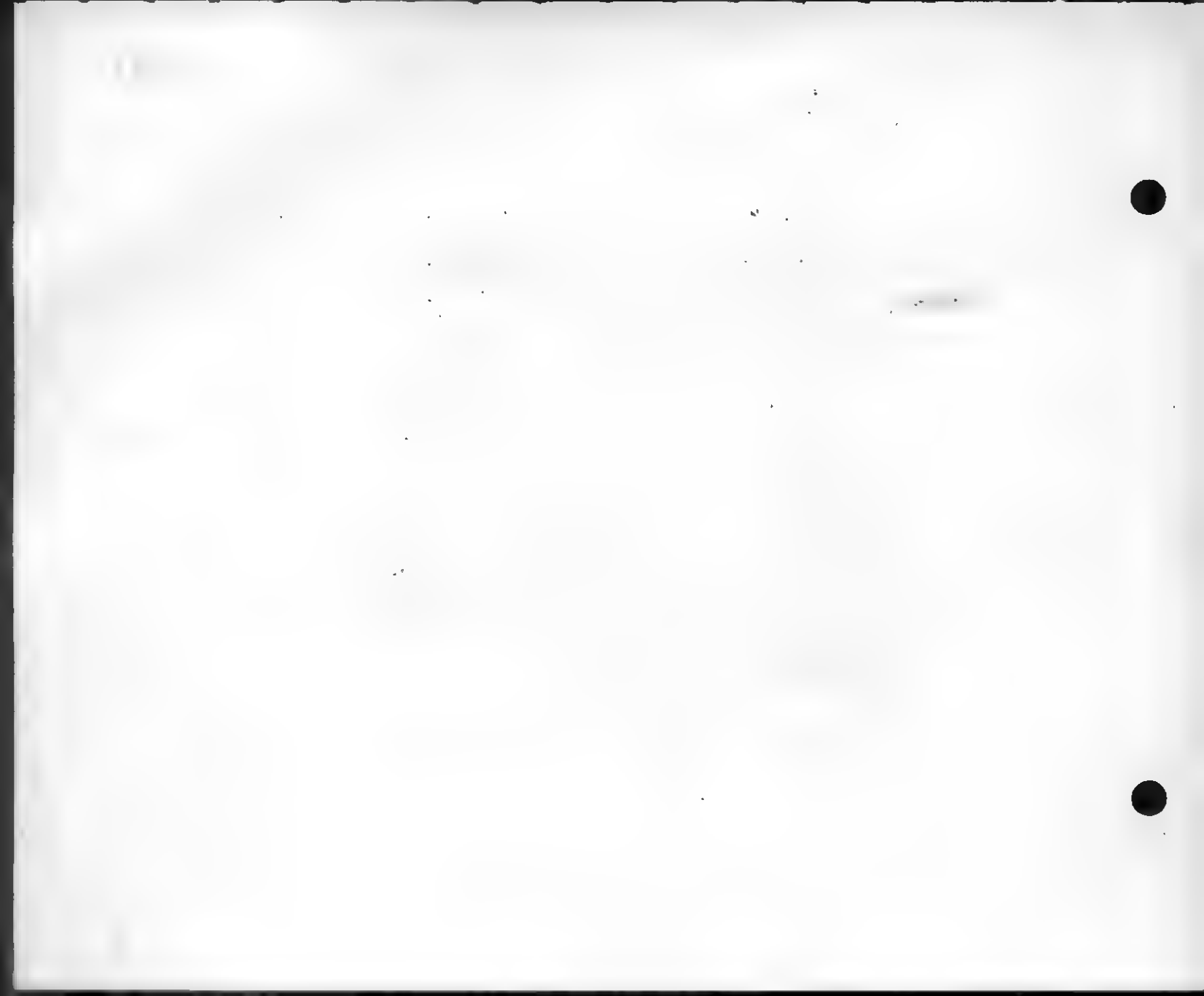


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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15395					15394						
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>GREATER Baltio. Medical Center</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wasson #4</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER Baltio. Medical Center</u>					d. STREET ADDRESS <u>305 Tollgate Rd. 6701 N. Charles Street</u>						
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>SMITH</u> Last <u>Howard</u>					4. DATE OF DEATH <u>11</u> Month <u>18</u> Day <u>19</u> Year <u>66</u>						
5. SEX <u>Male</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>11-18-66</u> 9. AGE (in years last birthday) <u>11</u> yrs. <u>25</u> Months <u>2</u> Days <u>2</u> Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY						
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md.</u>					12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME <u>WALTER Jeremiah SMITH</u>					14. MOTHER'S MAIDEN NAME <u>Carolyn C. Howard</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.						
17. INFORMANT <u>Mother</u> Address <u>305 Tollgate Rd. #214</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYALINE MEMBRANE DISEASE &gt; 12hrs.</u> DUE TO (c) <u>PREMATURITY</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>11/17</u>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3:33 pm, 19 66</u> , to <u>4:35 pm 11/18/1966</u> , that (I) (we) last saw the deceased alive on <u>11/18 19 66</u> , and that death occurred at <u>4:30 pm</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> M.D.					22b. DATE SIGNED <u>11/18/66</u>						
22c. PHYSICIAN'S NAME (Type) <u>LOIS ACHIMOVICH</u>					22d. ADDRESS <u>GREATER BALTIMORE MED. CENTRE</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>NCU. 22, 1966</u>					23b. DATE THEREOF <u>NOV. 22, 1966</u>						
23c. NAME OF CEMETERY OR CREMATORY <u>GREATER BALTO MED CTR</u>					23d. LOCATION (City, town or county) (State) <u>6701 NORTH CHARLES BALTO, MD.</u>						
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>6701 NORTH CHARLES</u>					25a. REC'D BY REGISTRAR <u>NOV 25 1966</u>						
					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

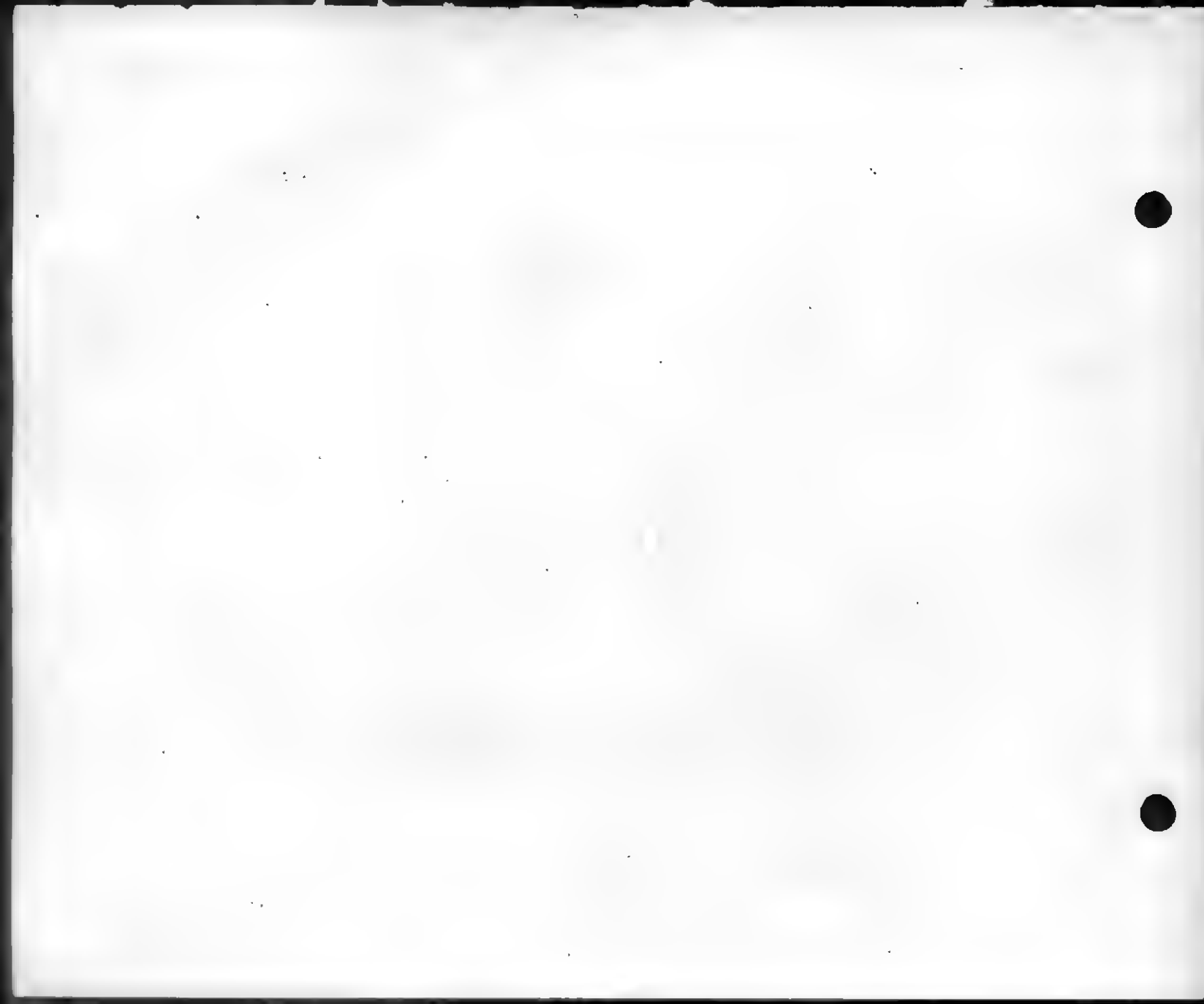


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, or institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
c. LENGTH OF STAY IN ID <u>18 days</u>		d. STREET ADDRESS <u>514 Hampton Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Centre</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert Edgar Smith</u>		4. DATE OF DEATH <u>Nov 23 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1893</u>
9. AGE (In years last birthday) <u>73 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Auto.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Can</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Can</u>		13. FATHER'S NAME <u>John Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Braddock</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-01-5568A</u>		17. INFORMANT <u>Mrs. Ethel M. Durrett</u> Address <u>514 Hampton Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO - Resp. Failure</u> DUE TO (b) <u>Peripheral arterial Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from <u>Nov. 5, 1966</u> to <u>Nov 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 23, 1966</u> , and that death occurred at <u>7:05 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Dennis Chan</u>		22b. DATE SIGNED <u>Nov 23 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>DENNIS CHAN</u>		22d. ADDRESS <u>9 B. M. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mobeland Memorial Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook Brooks</u>		25a. REC'D BY REGISTRAR <u>NOV 25 1966</u>	
ADDRESS <u>Towson 1050 York Rd. 21204</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15397

CERTIFICATE OF DEATH

15396

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u> 21-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE HOUSE NURSING HOME</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Imes</u> <u>IONE</u> <u>Smith</u>				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1888</u>	9. AGE (In years last birthday) yrs <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD R. TRITAPOE</u>				14. MOTHER'S MAIDEN NAME <u>ADA MAE CORDELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>WA-222303</u>		17. INFORMANT <u>BERTHA HOFFMAN - BALTIMORE MD</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-31-1966</u> , to <u>11-9-1966</u> , that (I) (we) last saw the deceased alive on <u>11-8-1966</u> , and that death occurred at <u>5:25 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u>				22d. ADDRESS <u>6209 Frederick Ave Balt. 21228, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BURKITTSVILLE CEMETERY -</u>		23d. LOCATION (City or town) (County) (State) <u>BURKITTSVILLE MD</u>	
24. FUNERAL DIRECTOR <u>Feete Funeral Home - BROWNSVILLE MD</u>				25a. REC'D BY REGISTRAR <u>NOV 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

11

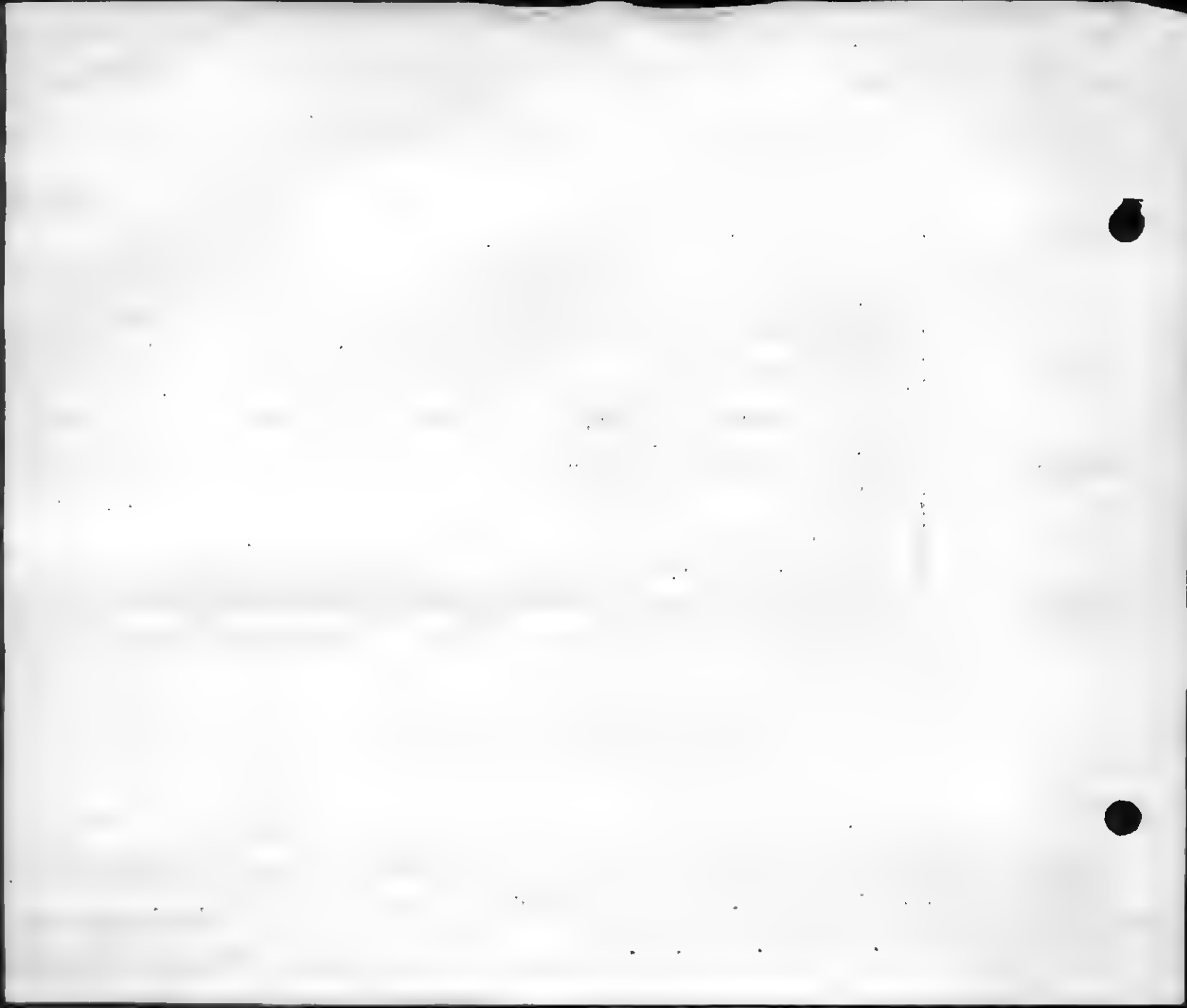


1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTO-RURAL - Parkville</b>		c. LENGTH OF STAY IN 1b <b>9 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTO-RURAL - Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7402 PARK DRIVE</b>		d. STREET ADDRESS <b>7402 Park Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <b>GEORGE WILLIAM SNEEL</b>		4. DATE OF DEATH <b>Nov. 6, 1966</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 APRIL 1905</b>		9. AGE (in years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Agent Stage Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Monongia West Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George SNELL</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA SPINACHE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8227</b>		17. INFORMANT <b>Ruth SNELL wife</b>		Address <b>same</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiac vascular disease - Probable terminal</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Artery Occlusion.</b> (c) <b>Coronary Artery Occlusion.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>John C. Hyle</b>		EXAMINER'S NAME (Type) <b>JOHN C. HYLE</b>		DATE SIGNED <b>6 Nov 66</b>		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/9/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		23. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		24a. REC'D BY REGISTRAR <b>NOV 9 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15399

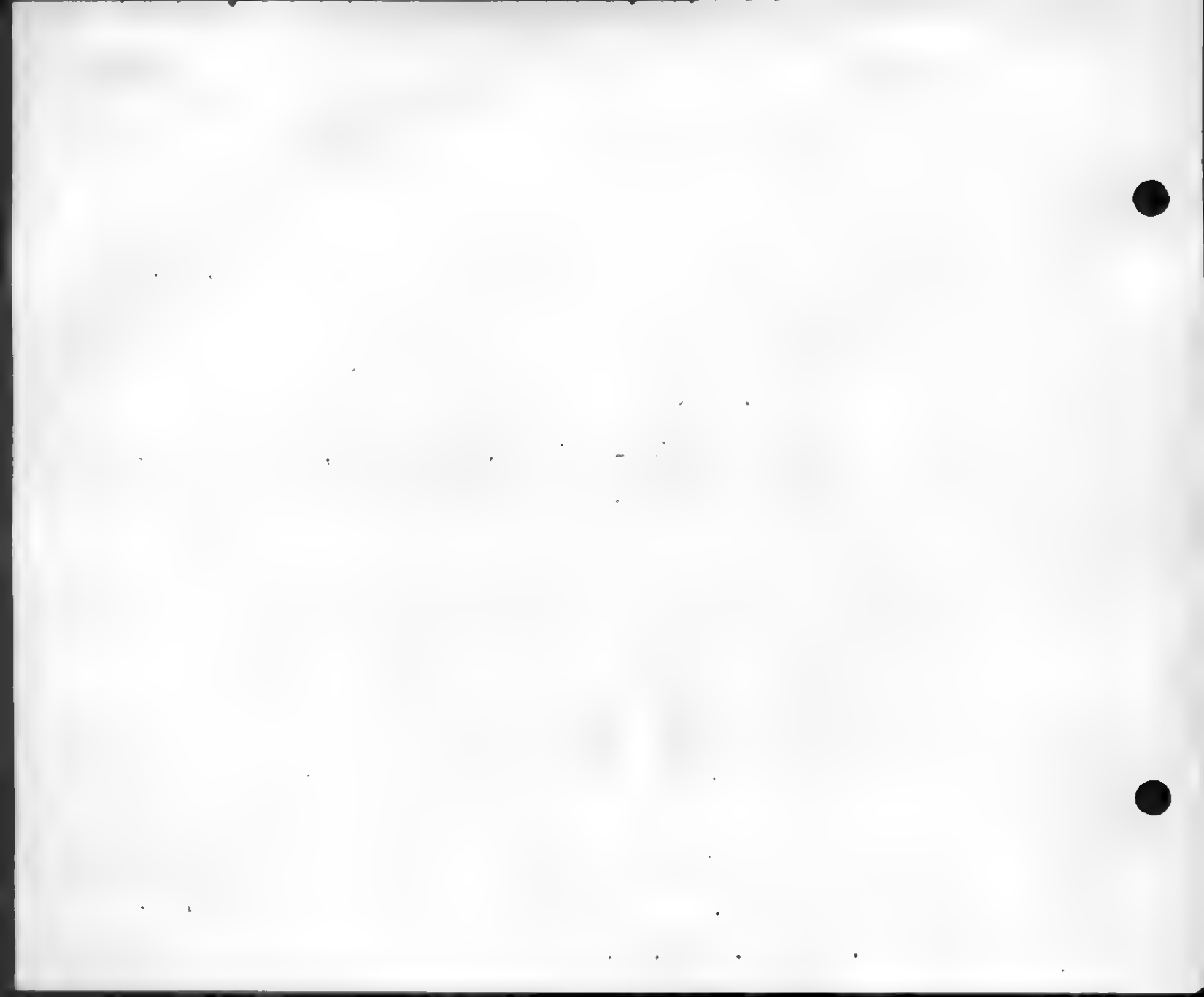
## CERTIFICATE OF DEATH

15398

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lawson - 4</b>		c. LENGTH OF STAY IN 1b <b>21214</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>2709 Gibbons Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>Bather</b> Middle <b>P.</b> Last <b>Snyder</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-94</b>
9 AGE (In years last birthday) <b>22 yrs</b>		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Queenstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter G. Cannon</b>		14. MOTHER'S MAIDEN NAME <b>Emma Lane</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>216-10-9222A</b>	
17. INFORMANT <b>Mrs. Ethel Graham, 5608 Tramore Rd. #14</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>5102</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mitral insufficiency; Congestive heart failure.</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 7, 1966</b> to <b>Nov. 22, 1966</b> that (I) (we) last saw the deceased alive on <b>Nov. 22, 1966</b> , and that death occurred at <b>11:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>M.S. Cockburn, M.D.</b>		22b. DATE SIGNED <b>11/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/26/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>NOV 25 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

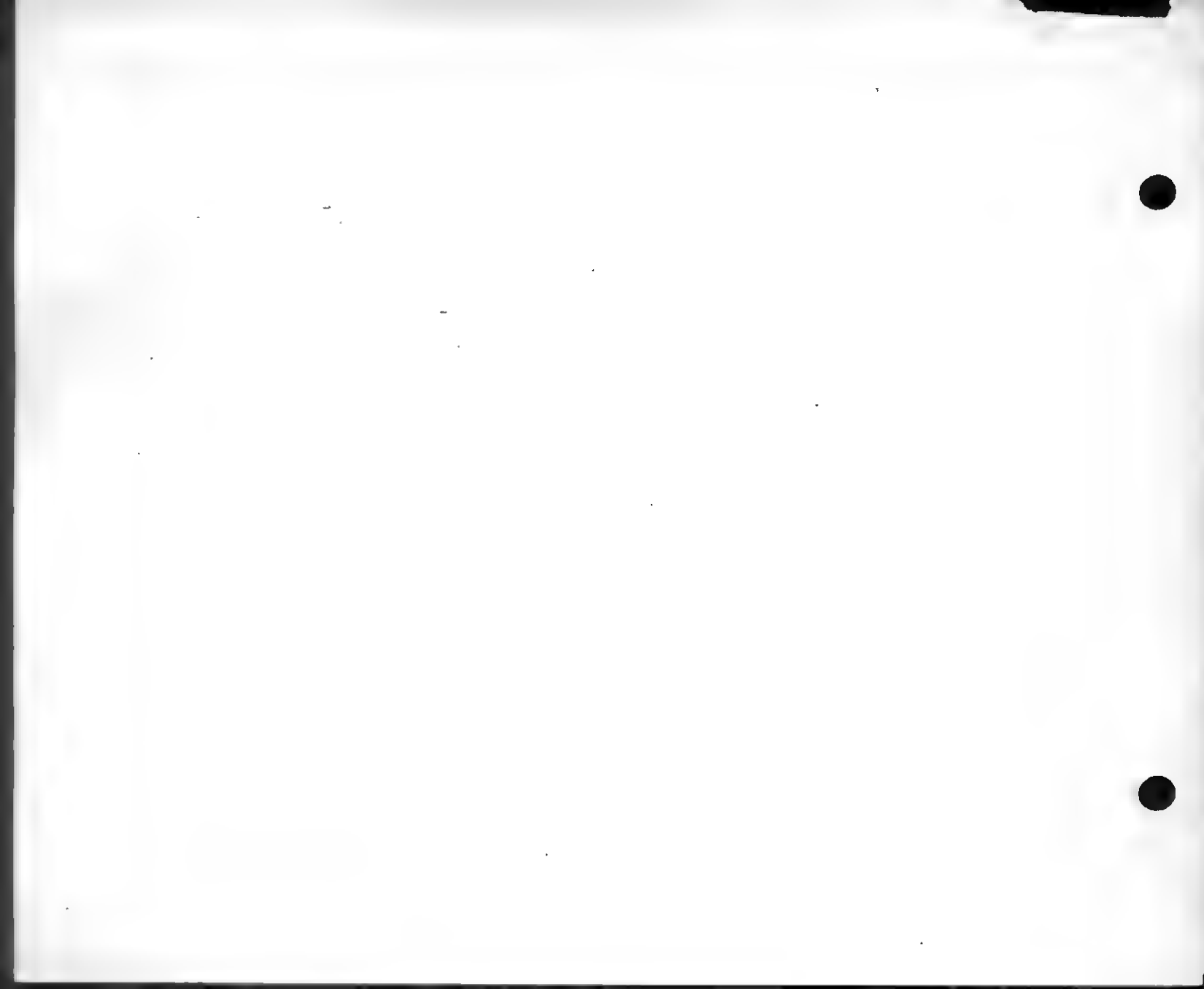
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15400

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15399

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Lutherville</b>		c LENGTH OF STAY in b <b>3 Mo.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1401 Jeffery Circle Jeffers Rd.</b>		d STREET ADDRESS <b>1401 Jeffery Circle Jeffers Rd.</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>RUSSELL</b> Middle <b>A.</b> Last <b>SNYDER</b>		4 DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-28-66</b>
9 AGE (In years lost birthday) yrs <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b></b> Hours <b></b> Min <b></b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER EMPLOYED</b>		10b KIND OF BUSINESS OR INDUSTRY <b></b>	
11 BIRTHPLACE (State or foreign country) <b>Towson, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William A. Snyder</b>		14 MOTHER'S MAIDEN NAME <b>Patricia Crist</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>NONE</b>	
17 INFORMANT <b>William A Snyder, 1401 Jeffers Rd.</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis (SDII)</b> DUE TO (b) <b></b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. <b>19</b> p.m. <b></b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>November 25, 1966</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Nov. 26, 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d LOCATION (City or Town) (County) (State) <b>Cockeysville, Balto. Md.</b>	
24 FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>		25a REC'D BY REGISTRAR <b>NOV 28 1966</b>	
ADDRESS <b>Towson, Md.</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



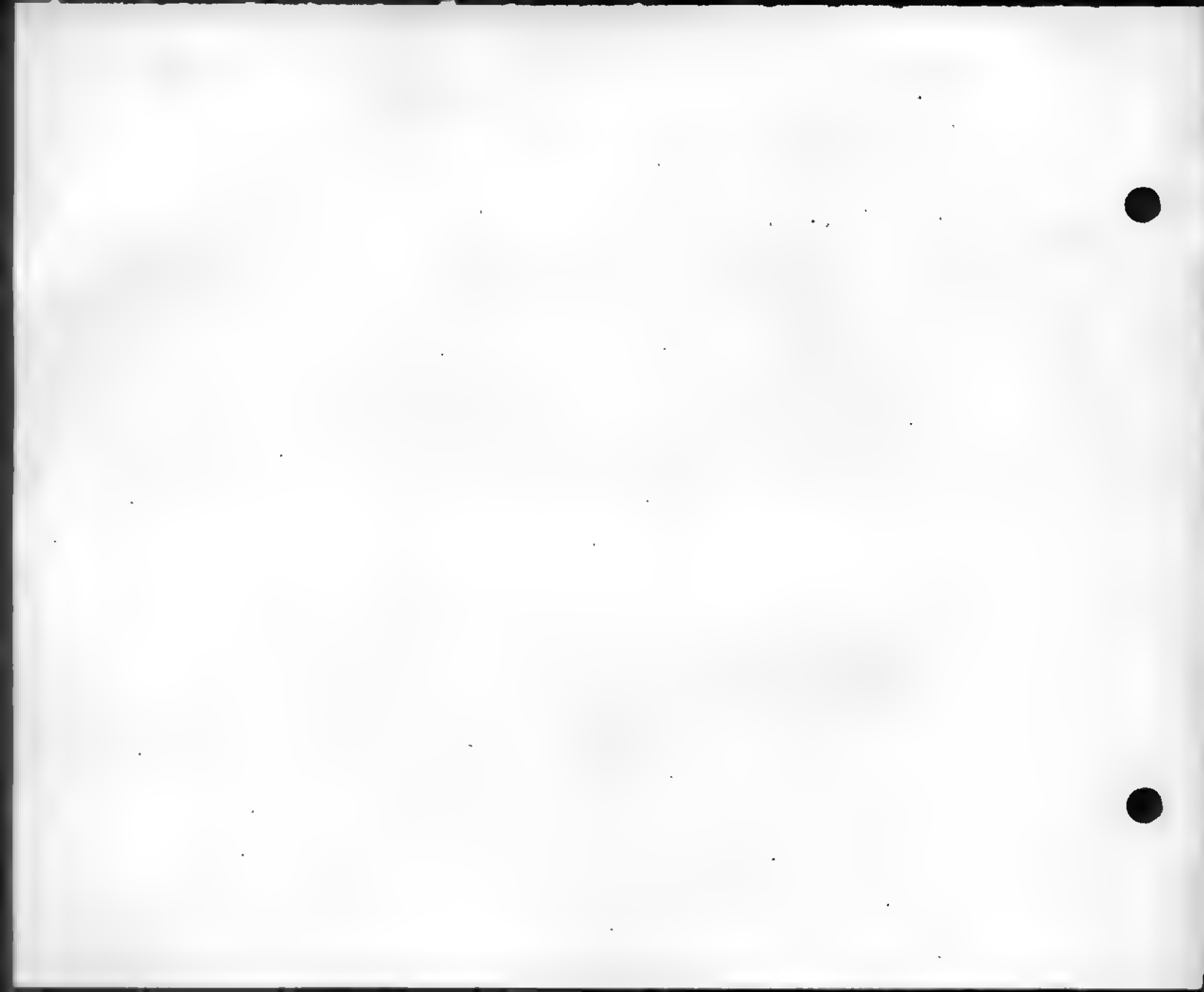


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15401 CERTIFICATE OF DEATH 15400

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>3 years, 9 mo.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				d. STREET ADDRESS <b>1124 Williams St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Woodrow</b>		First <b>Wilson</b>		Middle <b>Staggs</b>		Last <b>Staggs</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8.17.1913</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	10. Year <b>1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Staggs</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Newberry</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>278-03-4736</b>		17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor. Pulmonale</b> DUE TO (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2.5. 1963</b> , to <b>11.10. 1966</b> , that (I) (we) last saw the deceased alive on <b>11.10. 1966</b> , and that death occurred at <b>7:05 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11.11.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WARING CEM.</b>		23d. LOCATION (City, town or county) (State) <b>GARRISON, KY</b>	
24. FUNERAL DIRECTOR <b>JOHN F DENNY, INC. 715 LIGHT ST BALTIMORE, MD</b>				25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15402

15401

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>17 Skidmore Court</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21218</b> d. STREET ADDRESS <b>1638 East 32nd Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harry Lee Starr</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>29</b> Year <b>1966</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 16, 1900</b>	
<b>9. AGE</b> (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk Kopper's Co., Retired</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Baltimore, Maryland</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Harry Lee Starr Sr.</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Desverreaux</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>212-09-8865</b>		<b>17. INFORMANT</b> <b>Mrs Ruth D. Starr</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town) (County) (State)</b> _____	
<b>21. I certify that (I) (this) (the) (they) attended the deceased from _____, 1966 to _____, 1966 that (I) (we) last saw the deceased alive on _____, 1966, and that death occurred at _____ M. from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <b>William H. Fusting</b>		<b>22b. DATE SIGNED</b> <b>12/1/66</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>William H. Fusting</b>		<b>22d. ADDRESS</b> <b>4230 Lock Raven Blvd.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/3/66</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Park Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Woodlawn Maryland</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 7 1966</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		<b>25c. DATE</b> <b>DEC 7 1966</b>	

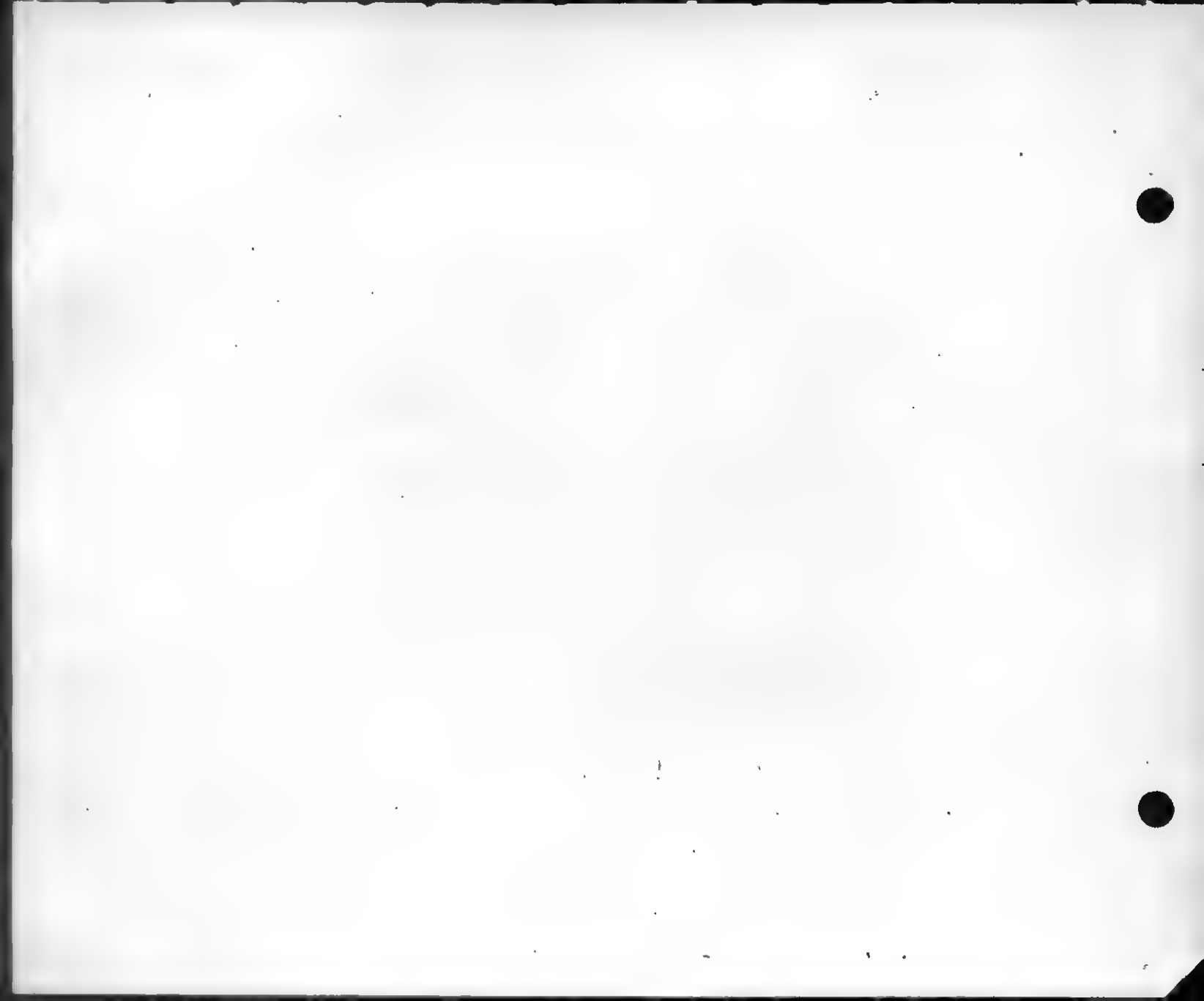
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15403						15402					
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE MARYLAND</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SWEET AIR + PATTERSON HOMES</u>						d. STREET ADDRESS <u>SWEET AIR + PATTERSON HOMES</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Emma Caroline Sterner</u>						4. DATE OF DEATH <u>Nov. 22, 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN STARKLAUF</u>						14. MOTHER'S MAIDEN NAME <u>SOPHIA MUELLER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>PAUL A. WIEGSCHE SWEET AIR PATTERSON HOMES</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>922.1</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>55</u> , to <u>Nov.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William A. Tyson</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-22-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>						22d. ADDRESS <u>Kingsville Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (S <input checked="" type="checkbox"/> I <input type="checkbox"/> Y)			23b. DATE THEREOF <u>Nov. 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc.</u>						ADDRESS <u>1217 S. Paul St. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>Nov 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15404

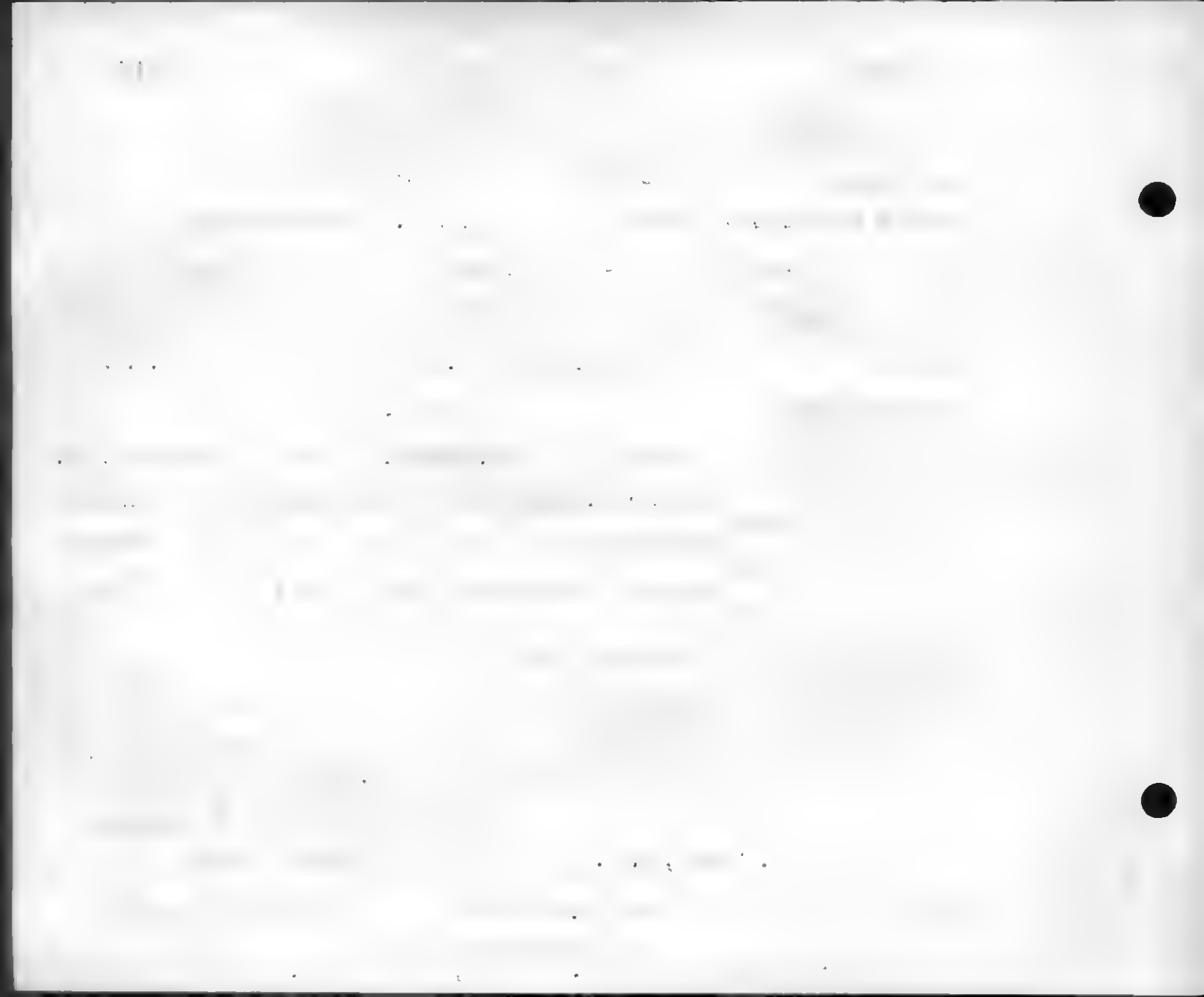
## CERTIFICATE OF DEATH

15403

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>36 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1724 E. LAFAYETTE AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>ARRY</b> Middle <b>--</b> Last <b>STEWART</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/15/12</b>
9. AGE (n years lost birthday) yrs <b>54</b>		10. IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min <b>---</b>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>HAMER, SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SHELTON STEWART</b>		14. MOTHER'S MAIDEN NAME <b>IDA J. MC NEILL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>215 09 91 37</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA WITH PULMONARY ABSSESSES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>SYRINGOMYELIA</b> (c) <b>DECUBITUS ULCERS SACRAL AREA AND HIPS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>---</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>10/21/66</b> , 19 <b>---</b> , to <b>11/26/66</b> , 19 <b>---</b> , that <b>he</b> (we) last saw the deceased alive on <b>11/26/66</b> , 19 <b>---</b> , and that death occurred at <b>7:00AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Jorge A. Fabara</b>		22b. DATE SIGNED <b>11/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-2-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>JOSEPH KNIGHT</b>		25a. REC'D BY REGISTRAR <b>JOSEPH KNIGHT FUNERAL HOME</b> DATE <b>DEC 7 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

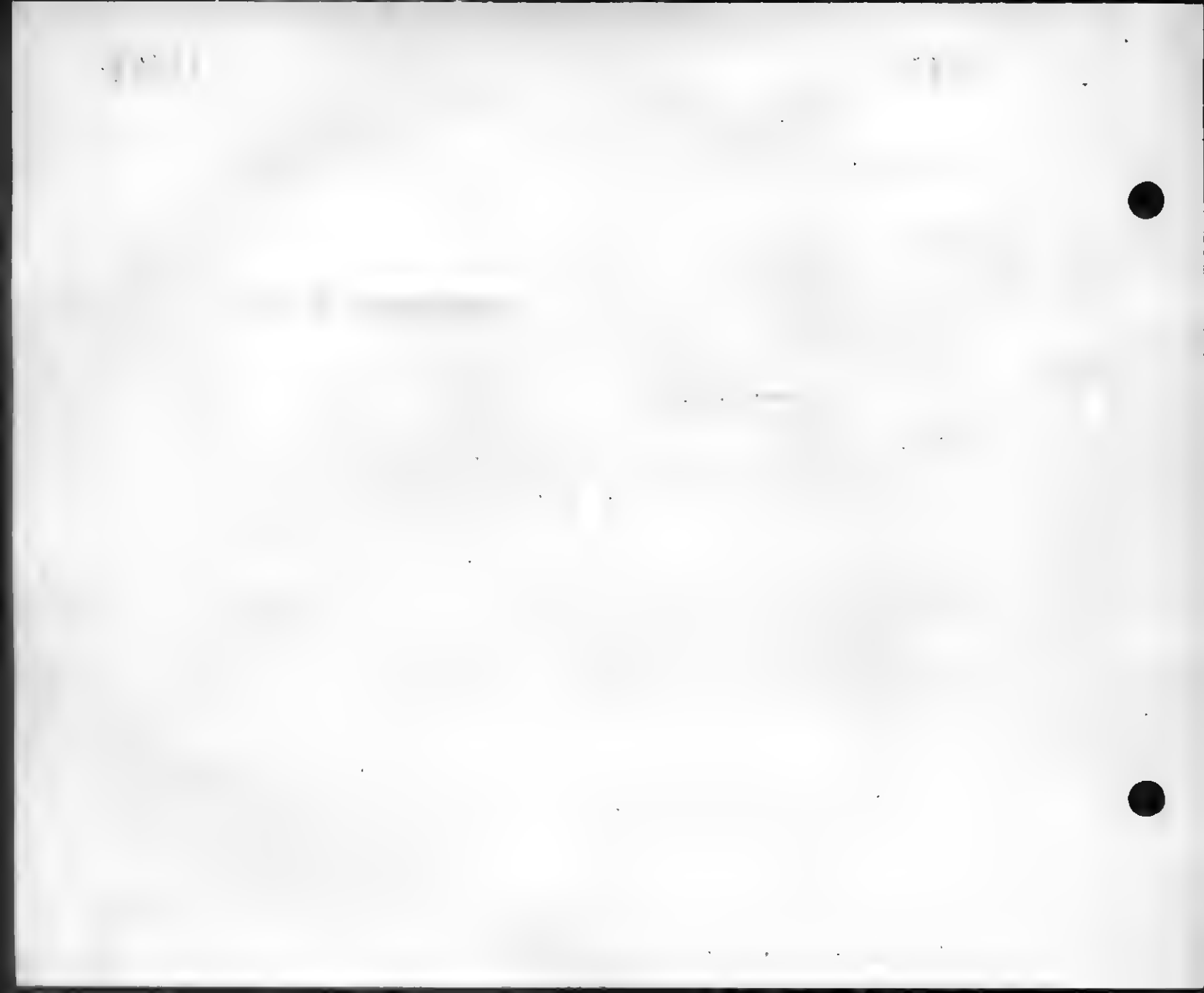
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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15405

15404

1. PLACE OF DEATH a. COUNTY <u>Folkeigh Nursing Home</u> <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY - <u>Balti City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3333 Clarke Lane</u>	
c. LENGTH OF STAY IN 1b <u>8 Days</u>		d. STREET ADDRESS <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Folkeigh Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Stefania</u> Last <u>Stefania</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900-01-01</u>
9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred KARCHER</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ely</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-48-7286</u>	
17. INFORMANT <u>MR. Jack Stofberg, 27 Brightside Avenue</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intra abdominal carcinoma</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>64</u> , to <u>11-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-9</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Leonard M. Kister</u>		22b. DATE SIGNED <u>11/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leonard M. Kister</u>		22d. ADDRESS <u>7111 Park Heights Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/11/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Iubawitz Nusi Ari</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>		25. REC'D BY REGISTRAR <u>NOV 14 1966</u>	
		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15406

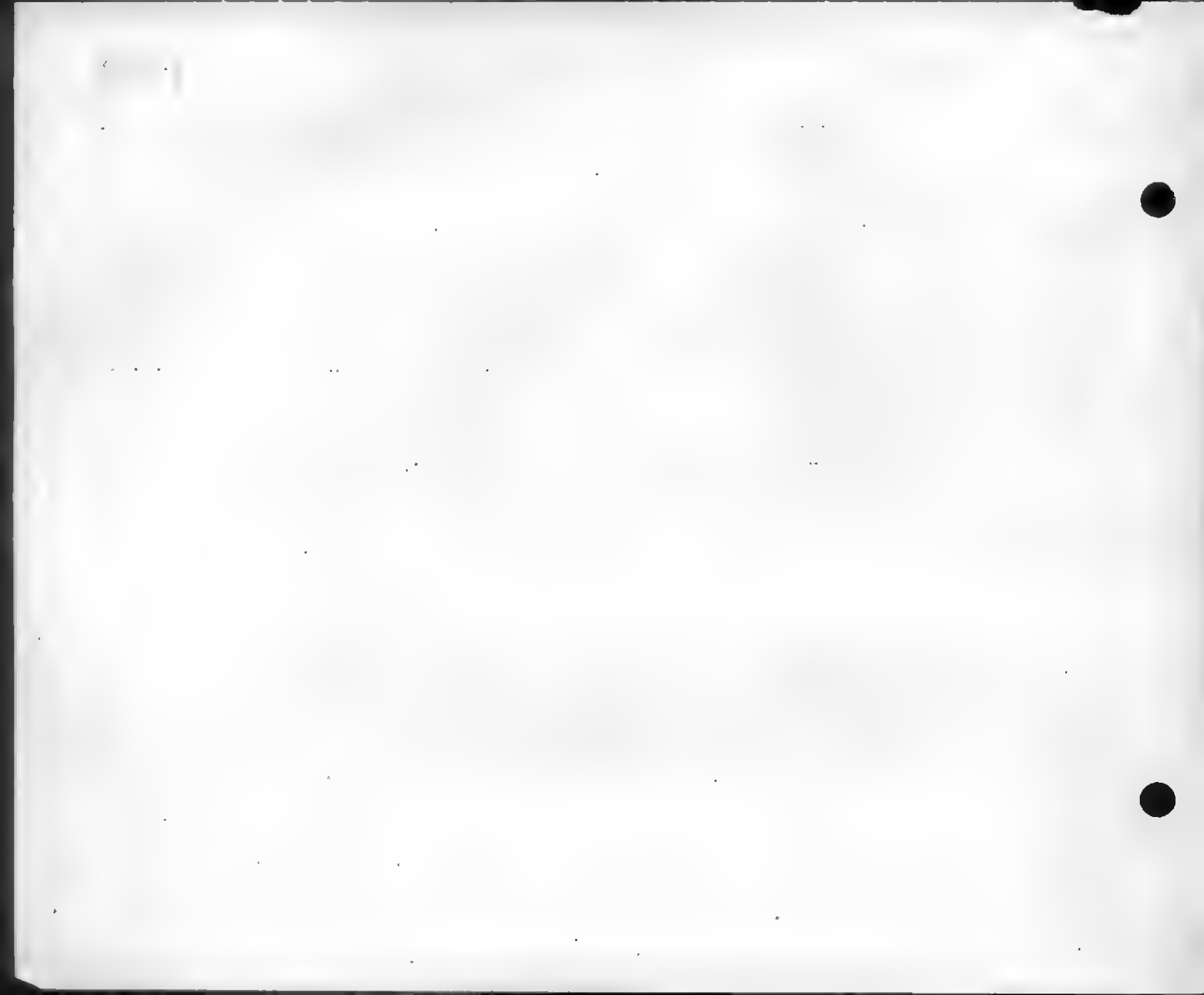
**CERTIFICATE OF DEATH**

15405

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver to the funeral home, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on the event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY in 1b <b>43 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>13.1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>108 LOCUST DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE PANCRATUS STORMER</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 5 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 21 95</b>		9. AGE (In years last birthday) <b>71</b> yrs	F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEPHONE INSTALLER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western-Electrical</b>		11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM STORMER</b>				14. MOTHER'S MAIDEN NAME <b>THERESA RICKMILLER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES HW-1</b>		16. SOCIAL SECURITY NO. <b>577 09 9815</b>		17. INFORMANT Address <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS, LEFT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (c) <b>DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b> <b>YEAR</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>Sept. 23, 19 66</b> to <b>Nov. 5, 19 66</b> , that (H) (we) lost the deceased alive on <b>Nov. 5, 19 66</b> , and that death occurred at <b>30 a.m.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Robert L. Handwerker</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11 5 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert L. Handwerker</b>				22d. ADDRESS <b>VAH, Ft. Howard, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 8, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto Md.</b>	
24. FUNERAL DIRECTOR <b>John T. Stansbury</b>				25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



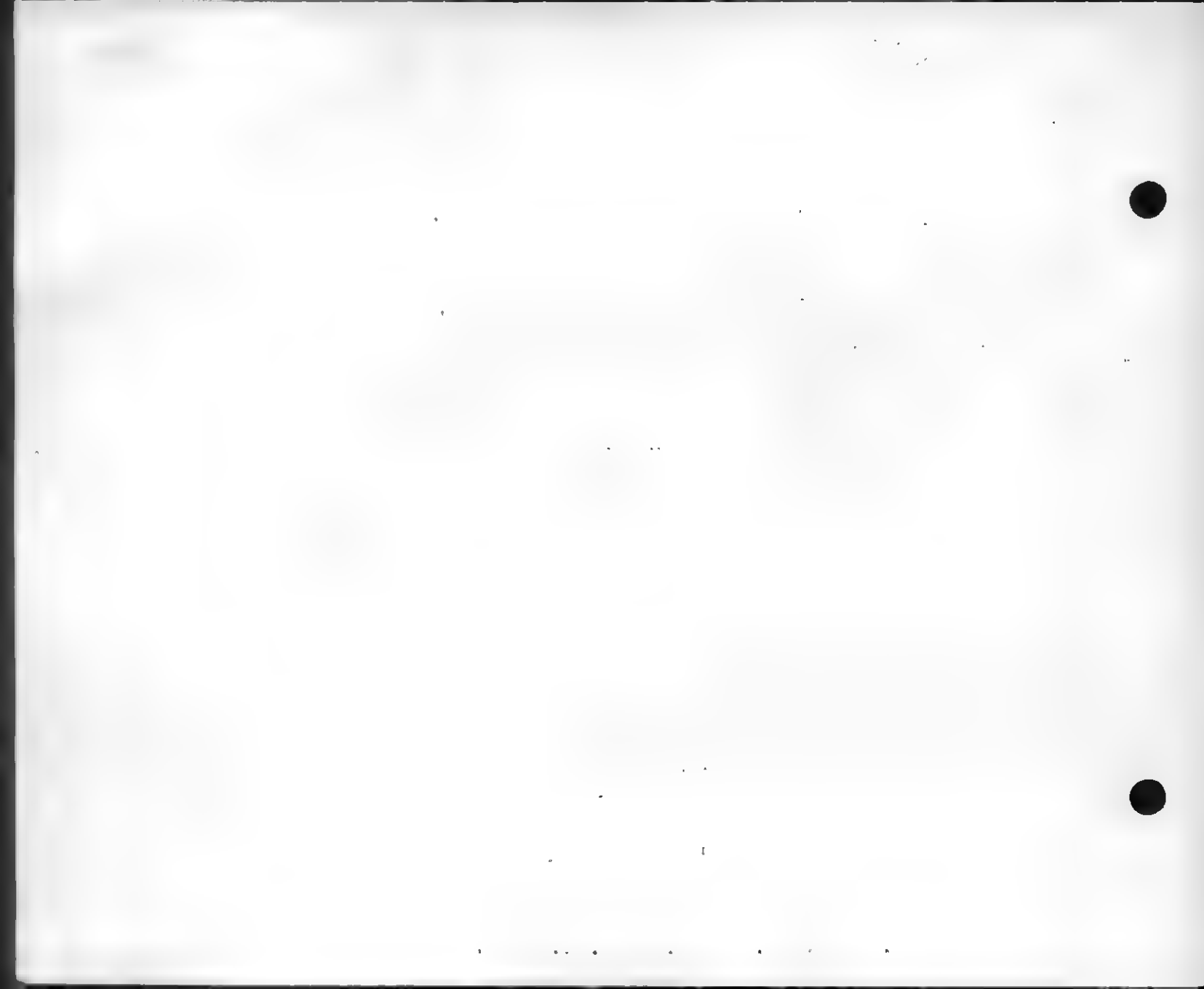
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15407 CERTIFICATE OF DEATH 15406

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>				c. LENGTH OF STAY IN ID			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armacost Nursing Home</u>				d. STREET ADDRESS <u>16 N. Lakewood Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>John</u> Last <u>Stuehler</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7, 1887</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. BIRTHPLACE (County & State, or foreign country)		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Martin Stuehler</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Lechner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-267-955</u>		17. INFORMANT <u>George Stuehler 16 N. Lakewood Ave. Balto.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular</u> DUE TO (c) <u>Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/15, 1966</u> to <u>11/5, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/18/66</u> and that death occurred at <u>11/5/66</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. O'Donnell</u> (M.D.)				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 13000 E. Balto. St. Balto.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE			
DATE <u>NOV 9 1966</u>							



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5H)  
6M 1/66

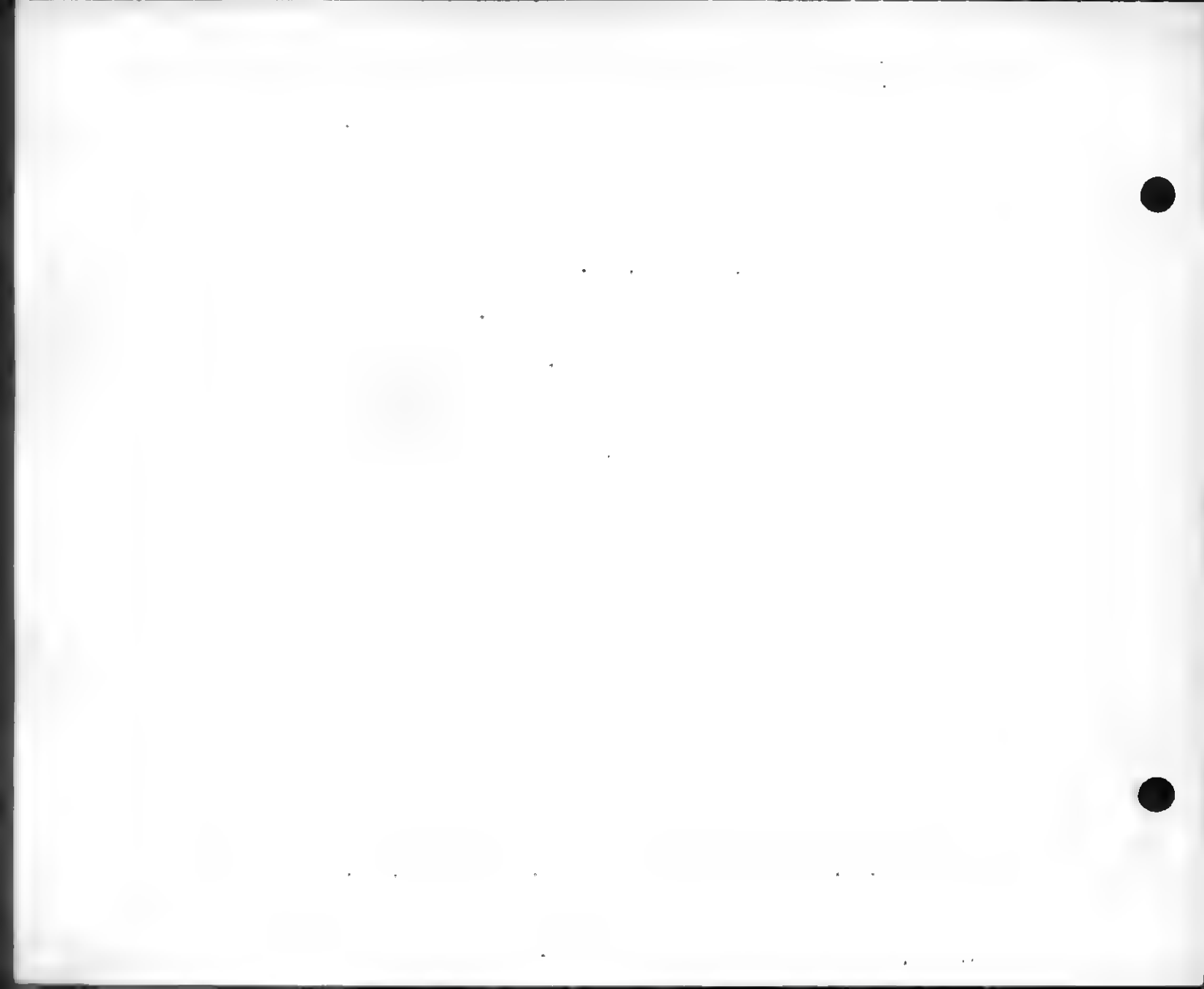
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15408

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15407

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1601 "H" Doolittle Road</b>		e STREET ADDRESS <b>1601 "H" Doolittle Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>HILBERT W. STUMPF, SR.</b>		4 DATE OF DEATH <b>November 25, 19 66</b>	
5 SEX <b>Male</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 2, 1891</b>
9 AGE (In years last birthday) <b>75</b> yrs		10 F UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperhanger</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Wall Paper Co.</b>	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Charles Stumpf</b>		14 MOTHER'S MAIDEN NAME <b>Margaret Ritger</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes-no or unknown) (If yes give war or dates of serv. etc.) <b>No</b>		16 SOCIAL SECURITY NO <b>214 20 1995</b>	
17 INFORMANT <b>Helen Stumpf</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO <b>A-S-C-V-DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b> M.D.		22. DATE SIGNED <b>11/26/66</b>	
EXAMINER'S NAME (Type) <b>M. B. Davis 6800 Mornington Rd. Dundalk 22, Md.</b>		23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b DATE THEREOF <b>11/29/66</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	
23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		25a REC'D BY REGISTRAR <b>NOV 29 1966</b>	
24 FUNERAL DIRECTOR <b>James E. Bruzdziński 1407 Eastern Ave. Balto.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15409

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15408

1 PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c LENGTH OF STAY N 1b <b>3 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 7587 Ives Lane</b>		d STREET ADDRESS <b>7587 Ives Lane 21222</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Mae Tare</b>		4 DATE OF DEATH Month Day Year <b>November 8- 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 11- 1913</b>
9 AGE (In years last birthday) <b>53</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Andy Adams</b>		14 MOTHER'S MAIDEN NAME <b>Mary Slifka</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOC. SEC. NO. <b>277-14-9758</b>	
17 INFORMANT <b>Husband, Mr. Steve Tare, #2, a, b, c, d.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension C-V Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b> EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		22. DATE SIGNED <b>11-9-1966</b>	
23a. BURIAL CREMATION, REINTERMENT (Type) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 12-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Youngstown, Ohio</b>	
24 FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25a. REC'D. BY REGISTRAR DATE <b>Nov 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

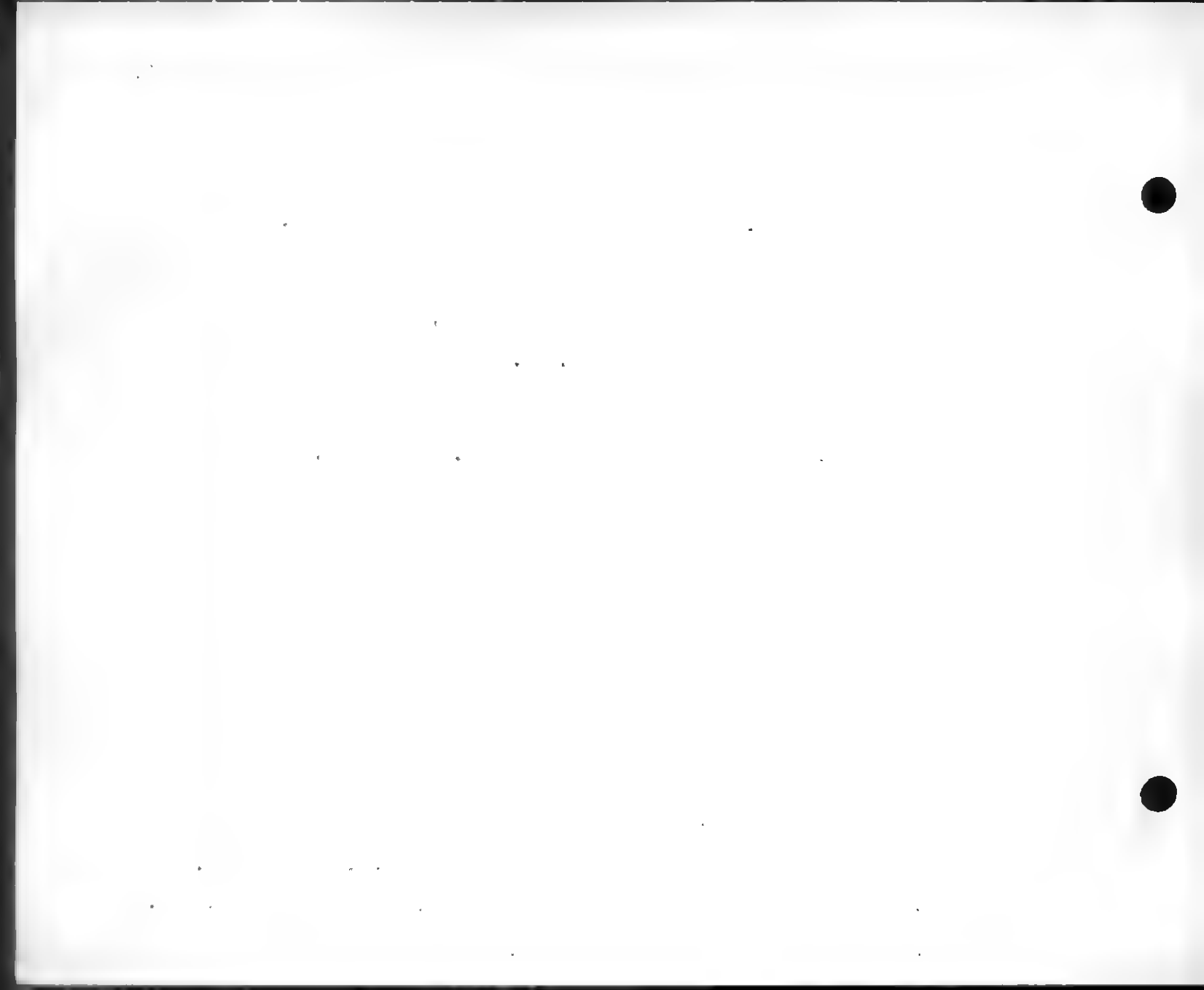
FOR STATE  
HEALTH DEPT.

15410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15409

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>309 Sassafrass Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Walter Taylor</b>				4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1966</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 19, 1883</b>		9 AGE (In years last birthday) <b>83</b> yrs	10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11 IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Tool Designer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Mfg. Co.</b>		11 BIRTHPLACE (State or foreign country) <b>Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212 07 7147A</b>		17. INFORMANT <b>James S. Gerber, Sr.</b>		Address <b>Same</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), (c)) PART I DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> pm <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <b>11/9/66</b>
ACTUAL SIGNATURE <b>Theo C. Patterson</b>		EXAMINER'S NAME (Type) <b>THEO C. PATTERSON</b>		22. DATE SIGNED <b>11/9/66</b>		23. LOCATION (City or town) - (County) (State) <b>Baltimore Co., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk.</b>		23d. LOCATION (City or town) - (County) (State) <b>Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home 1407 Eastern Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15411

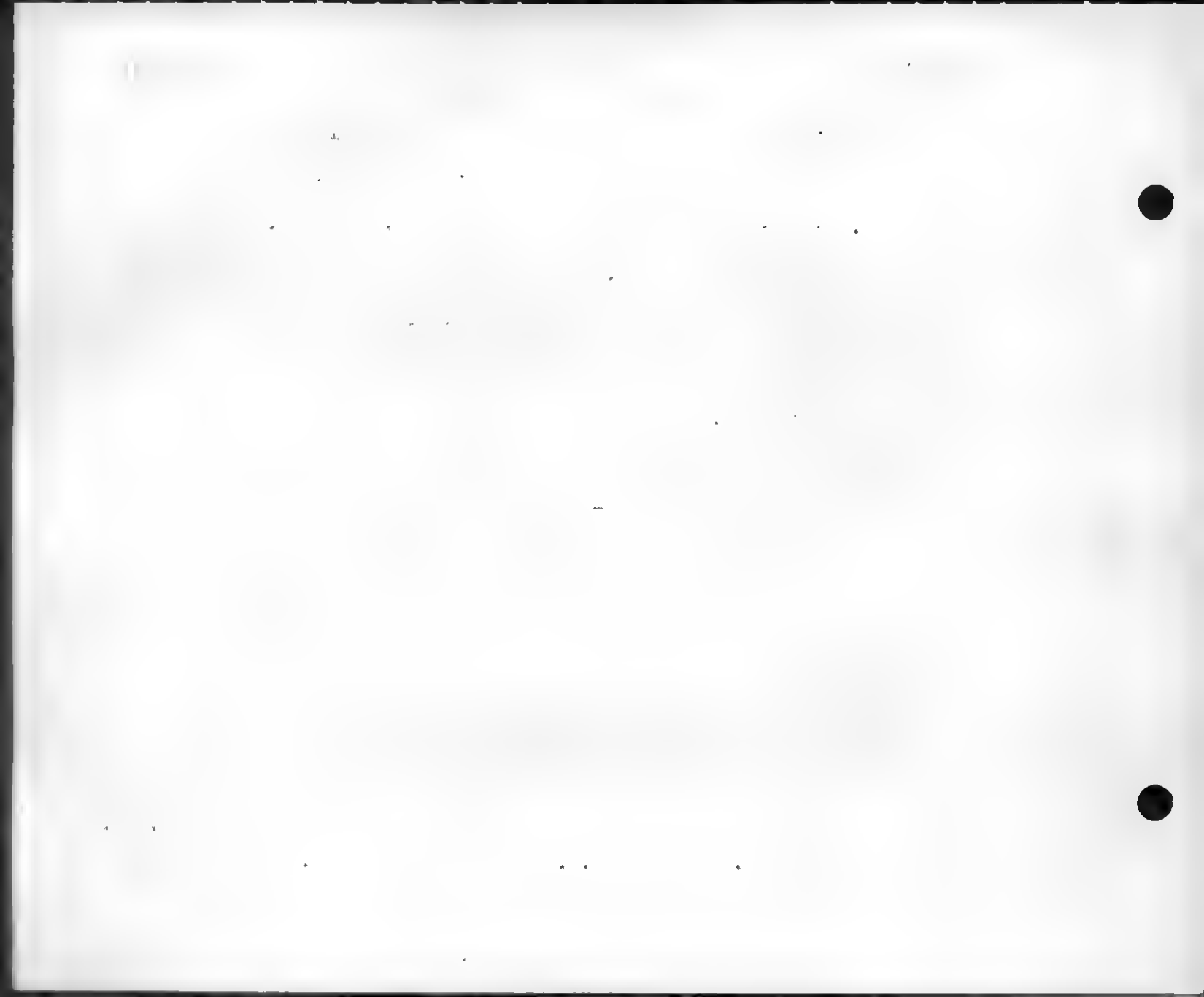
## CERTIFICATE OF DEATH

154110

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		d. STREET ADDRESS <b>3237 E. Joppa Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>G.</b> Last <b>TEAL Jr.</b>		4 DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1966</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>1914</b> <b>Sept. 8, 1914</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brickmason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert G. Teal Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Shanklin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-01-5165</b>	
17. INFORMANT <b>Dr. Monroe Teal</b>		Address <b>9531 12th Street Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebro-vascular Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <b>13</b>
21. I certify that (I) (this hospital) attended the deceased from <b>November 11 1966</b> , to <b>November 13 1966</b> , that (I) (we) last saw the deceased alive on <b>November 13 1966</b> , and that death occurred at <b>12:35 am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Nelson S. de la Paz</b>		22b. DATE SIGNED <b>Nov. 13, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Nelson S. de la Paz M.D.</b>		22d. ADDRESS <b>7620 York Rd. Towson 21204</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>11-17-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Lassal Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 16 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15412

CERTIFICATE OF DEATH

15411

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10yr8mth6dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>320 Millington Ave, Balto.23</b>	
3 NAME OF DECEASED (Type or print) First <b>MAX</b> Middle <b>THOMA</b> Last <b>THOMA</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-7-1901</b>
9 AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>4</b> Hours <b>11</b> Min <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Thoma</b>		14. MOTHER'S MAIDEN NAME <b>Ma tilda Kalhamer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-03-9661</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-28-56</b> , 19 <b>56</b> , to <b>11-4</b> , 19 <b>66</b> , that <b>we</b> last saw the deceased alive on <b>11-4</b> , 19 <b>66</b> , and that death occurred at <b>3:40AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>11-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>STERLING FUNERAL ESTATE Catonsville, Md.</b>		25. REC'D BY REGISTRAR <b>736 Edmondson Av.</b>	
25a. DATE <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

0-1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15413

CERTIFICATE OF DEATH

15412

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN IL <b>32 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>113 SOUTH TREMONT ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ELMER</b> Last <b>TRIESCHMAN</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>SUPERMARKET</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>RANDALLSTOWN, MARYLAND</b>		13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. FATHER'S NAME <b>WILLIAM TRIESCHMAN</b>		15. MOTHER'S MAIDEN NAME <b>ANNIE SMALLWOOD</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES</b> <b>WW I</b>		17. SOCIAL SECURITY NO <b>212 01 87 98</b>	
18. INFORMANT <b>VA HOSPITAL</b>		19. CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF RIGHT MIDDLE CEREBRAL ARTERY</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVA. BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETIS MELLITUS</b>		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT 19</b> , 19 <b>66</b> , to <b>NOV 20</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV 20</b> , 19 <b>66</b> , and that death occurred at <b>1230M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. Adatepe</b>		22b. DATE SIGNED <b>11 20 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MUSTAFA H ADATEPE M.D.</b>		22d. ADDRESS <b>VET ADM HOSP FT HOWARD MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-23-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Witzke Funeral Directors</b> <b>4101 Edmondson Ave.</b> <b>Baltimore 29, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)  
20 M 1/66

1

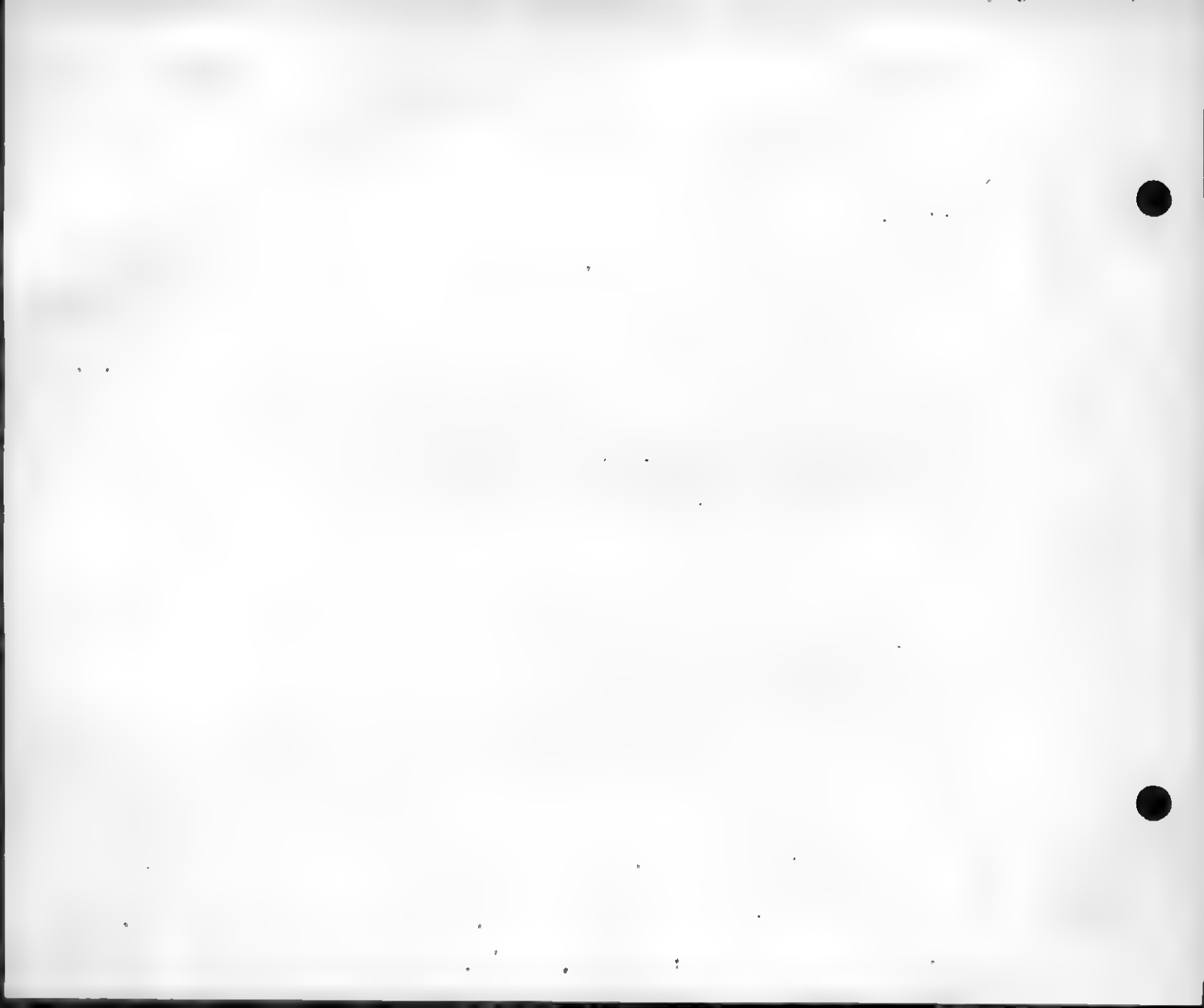
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15414

CERTIFICATE OF DEATH

15414

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>XXXXXX</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d STREET ADDRESS <b>701 Cedarcroft Road,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>M.</b> Last <b>TROTT</b>		4 DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1966</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-24-95</b>
9. AGE (in years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>66</b> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Stroehla</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Sichert</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-20-8033A</b>	
17 INFORMANT <b>Joseph C. Trott</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4541</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peritonitis, localized</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>October 1, 1966</b> to <b>Nov. 20, 1966</b> , that (1)(we) last saw the deceased alive on <b>November 20, 1966</b> , and that death occurred at <b>10:06 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>M.S. Cockburn</b>		22b. DATE SIGNED <b>11/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11/23/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d LOCATION (City or Town) (County) (State) <b>Parkville, Balto. Co., Md.</b>	
24 FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

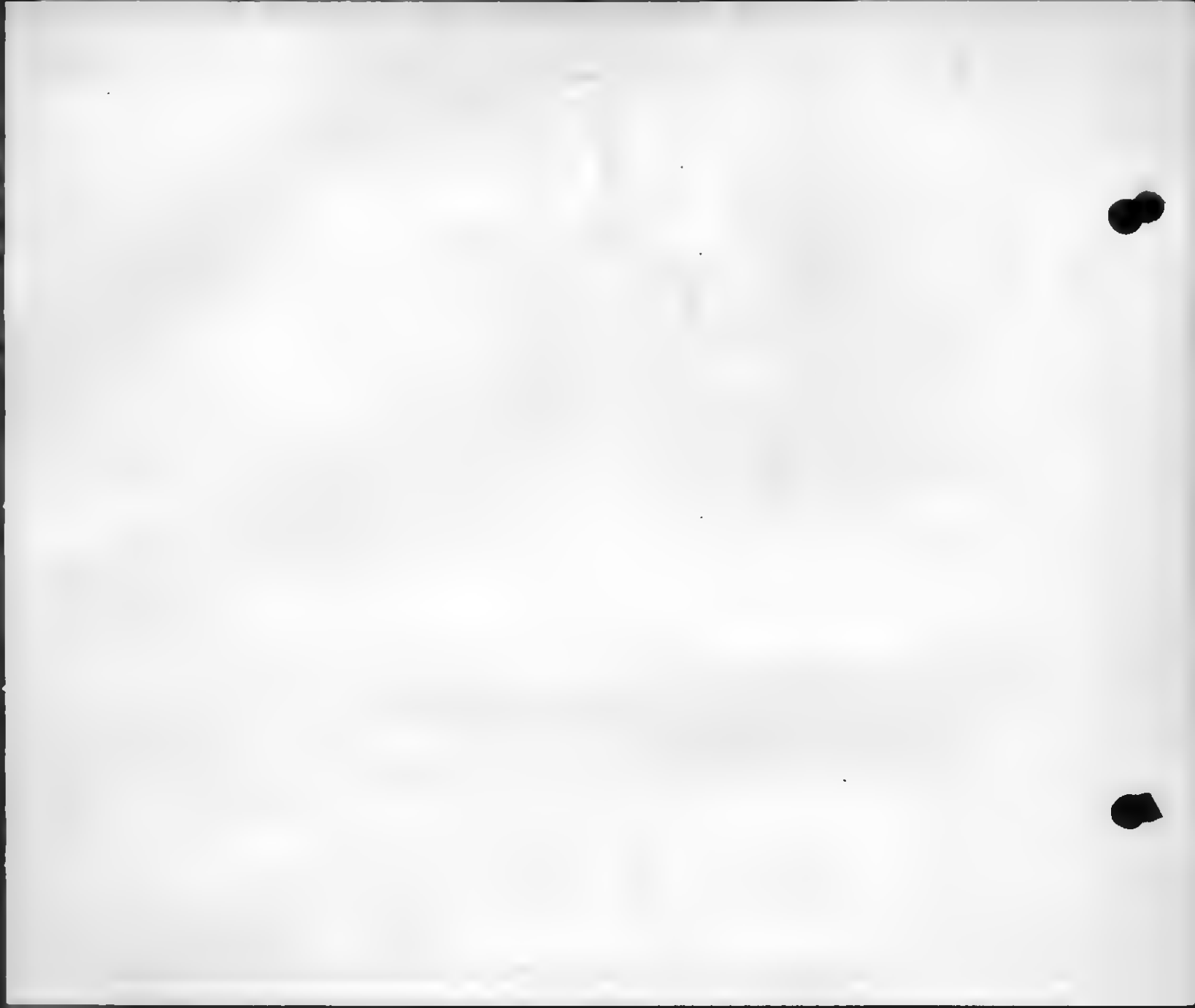
15414

15415

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>12 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven Convalescent home</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2815 Kirk Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Percy H Tucker</b>		4. DATE OF DEATH Month Day Year <b>Nov 26, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 18, 1883</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stationary</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>? Ticker</b>		14. MOTHER'S MAIDEN NAME <b>? Wiley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>111-11-1111</b>	
17. INFORMANT <b>Mrs Elizabeth Carlson</b>		Address <b>5000 Conant Way Baltimore Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Hypertension</b> DUE TO <b>Chronic Hypertension</b> (c) <b>Chronic Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>11/26/66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/26/66</b> to <b>11/26/66</b> , that I last saw the deceased alive on <b>11/26/66</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John H. Simon M.D. 5824 E. Conant Ave. 11/28/66</b>			
ACTUAL SIGNATURE <b>John H. Simon</b>		PHYSICIAN'S NAME (Type) <b>John H. Simon</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville Balto Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Simon</b>		24a. REC'D BY REGISTRAR <b>John H. Simon</b>	
ADDRESS <b>2713 Kirk Ave Balto Md</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The funeral director, the funeral director, or the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15416

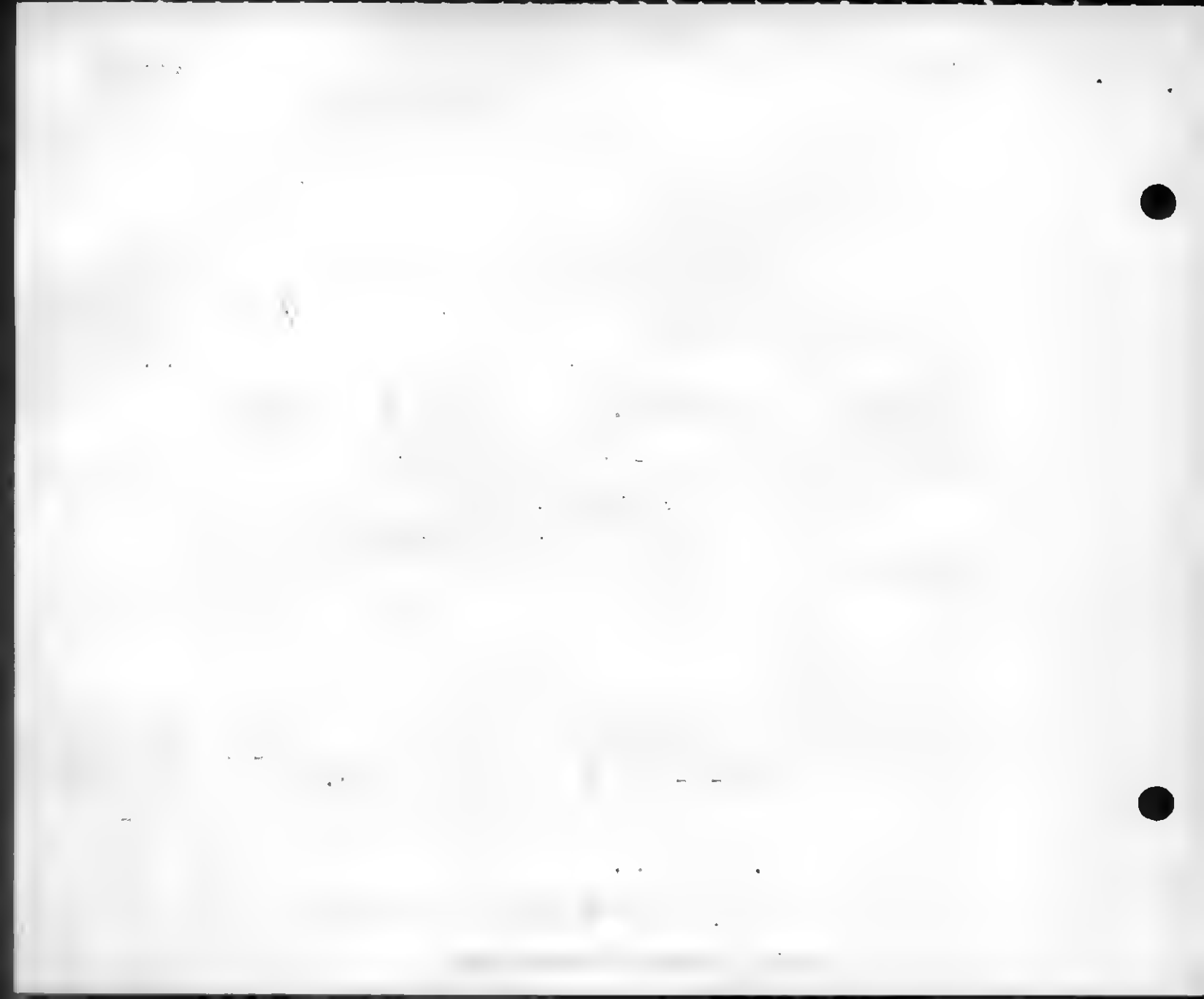
## CERTIFICATE OF DEATH

15415

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>L.</b> Last <b>Turner</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-94</b>
9 AGE (In years and months) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco Industry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>CHARLES L. TURNER</b>	
14. MOTHER'S MAIDEN NAME <b>LILLIE BURNS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16 SOCIAL SECURITY NO. <b>217-32-0873</b>		17 INFORMANT Address <b>Spring Grove State Hospital</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-28-66</b> , 19 <b>66</b> , to <b>11-25-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-24-</b> , 19 <b>66</b> , and that death occurred at <b>3 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>11-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d ADDRESS <b>Spring Grove State Hospital</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>11-28-66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>ST MARYS Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>AQUASCO, MD.</b>	
24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME, WALDORF, MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

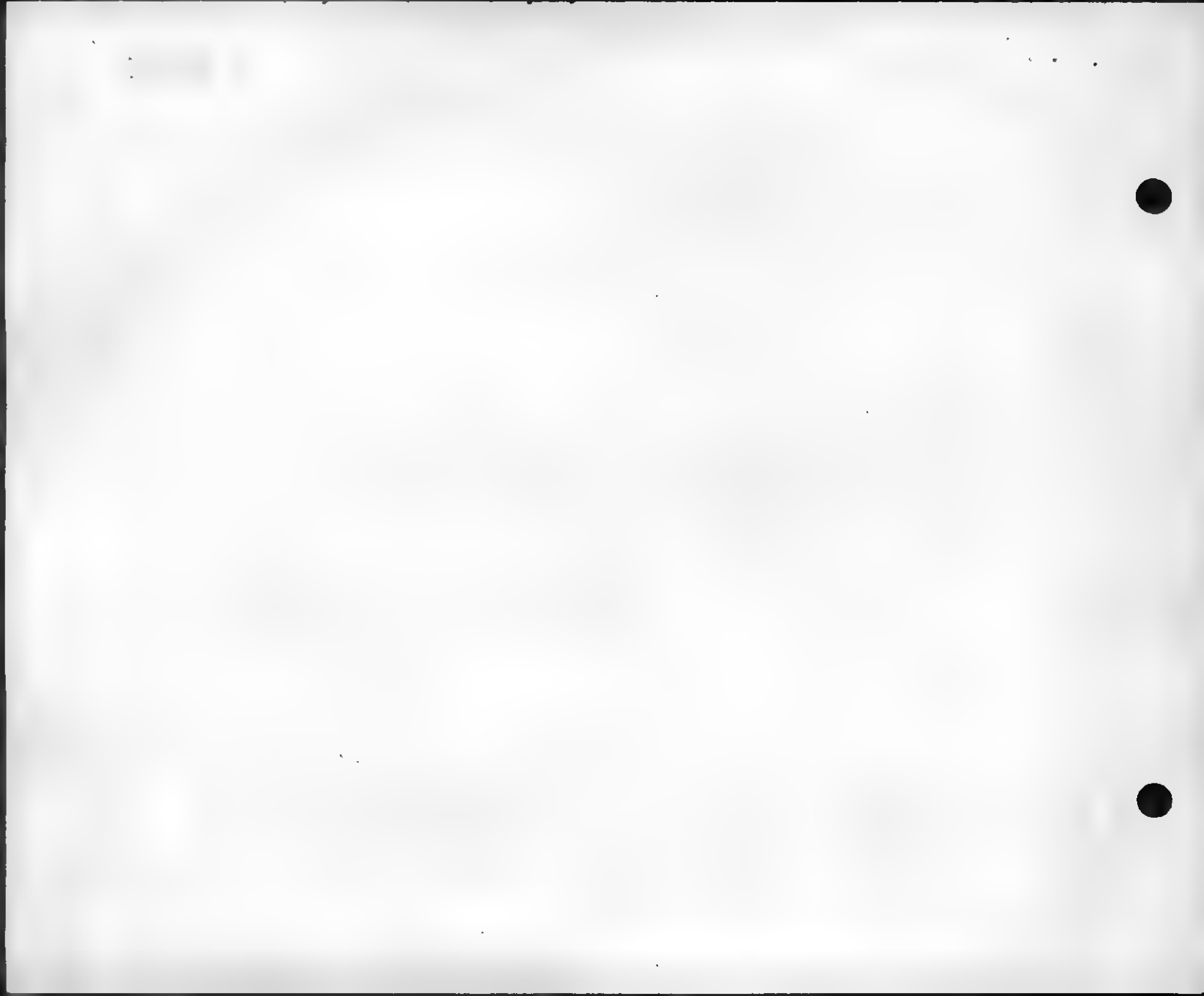
15417

## CERTIFICATE OF DEATH

15416

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp.</u>		e. STREET ADDRESS <u>3614 Bellmore Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph E. VAN HORN</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>14</u> - Year <u>1966</u>	
5. SEX <u>M</u>	6. CLDR DR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1891</u>
9. AGE (In years lost birthday) <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>	
11. BIRTHPLACE (County & State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Lindsay Van Horn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fetzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes W W I</u>		16. SOCIAL SECURITY NO <u>705-05-0073</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> , 19 <u>66</u> , to <u>11-14</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-14-66</u> 19 <u>66</u> , and that death occurred at <u>2:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. G. Patricio</u>		22b. DATE SIGNED <u>11-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Patricio</u>		22d. ADDRESS <u>Balt. Co. Gen. Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Liberty P. Dav 7</u>
24. FUNERAL DIRECTOR <u>Loring Byers - 8728 Liberty Rd</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

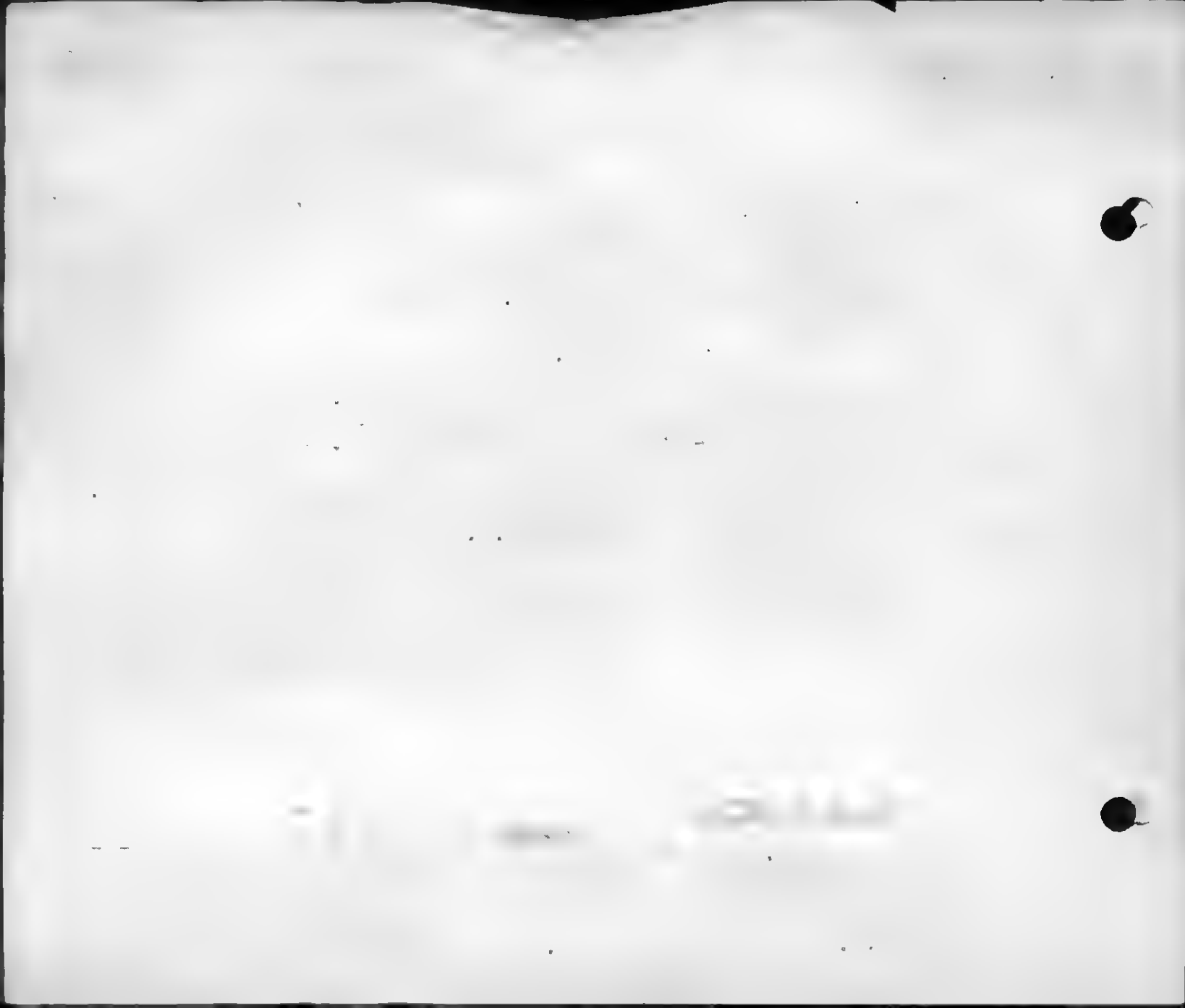
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 **FOR STATE HEALTH DEPT**  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If and when necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM  
SM 1/62

MAY 1966											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
15418											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before death if not) b. STATE <b>Md.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Laura Jane Vanneman</b>				4. DATE OF DEATH Month Day Year <b>Nov. 6 19 66</b>				5. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. <b>58 yrs.</b>			
6. COLOR OR RACE <b>Wh</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Apr. 20, 1908</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>				11. BIRTHPLACE (State or foreign country) <b>New York</b>			
13. FATHER'S NAME <b>Late - Elmer Wayson</b>				14. MOTHER'S MAIDEN NAME <b>Late - Mary E. Husselbaugh</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>219-20-5435</b>				16. SOCIAL SECURITY NO. <b>219-20-5435</b>				17. INFORMANT Address <b>Mr. Vernon A. Vanneman - Vanneman</b> <b>3702 Collier Rd. - Randallstown</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Coronary Thrombosis</b>											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic C.V. Disease</b>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <b>11-7-66</b>											
ACTUAL SIGNATURE <b>Martin E. Strobel</b>											
EXAMINER'S NAME (Type) <b>Martin E. Strobel</b>											
Address (Street, city, town, or county) (State)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
22b. DATE THEREOF <b>11-9-66</b>											
22c. NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>											
22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>											
23. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D. - 4101 Edmondson Av.</b>											
24a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>											
24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. Five pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

FOR STATE HEALTH DEPT.

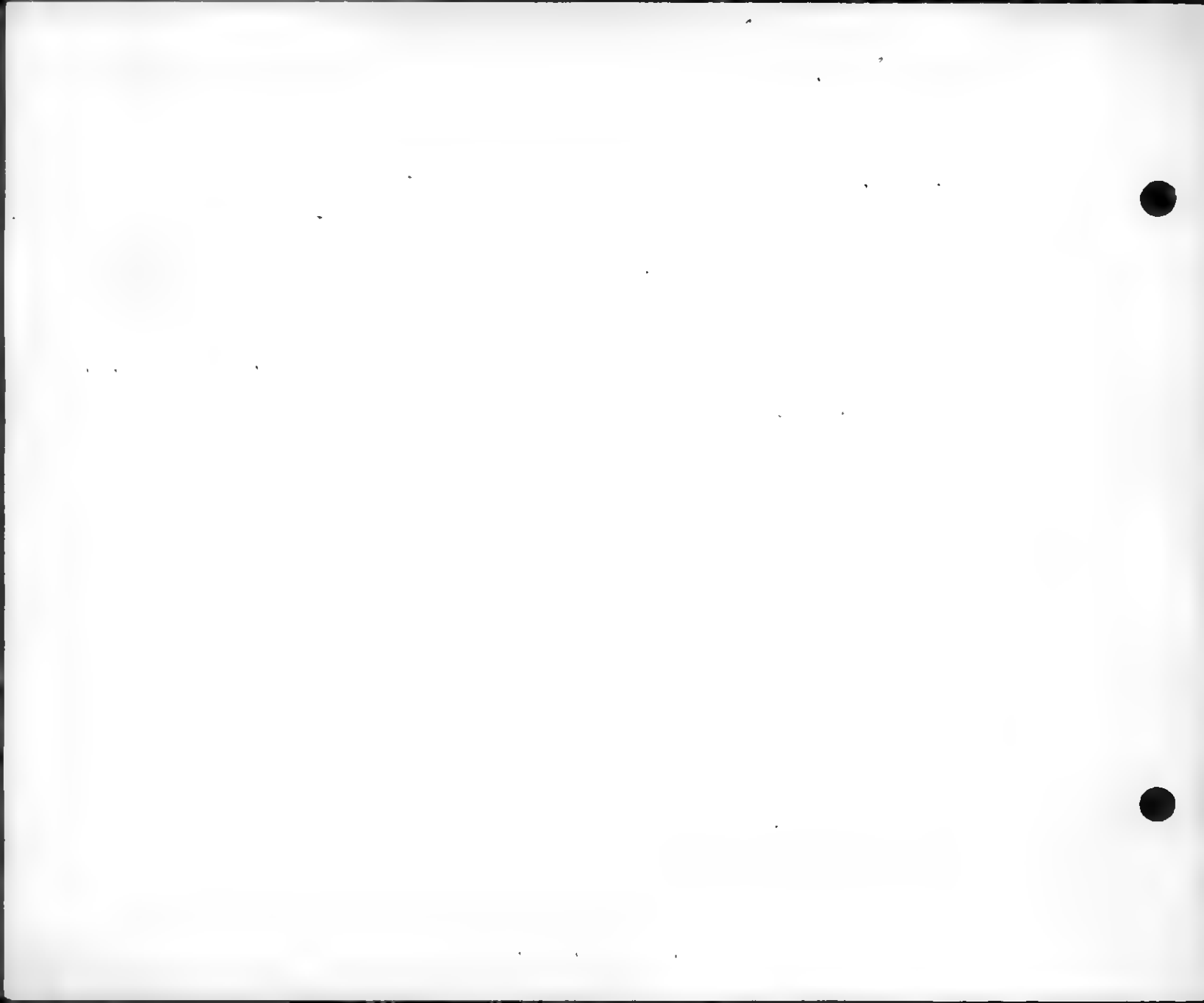
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15419

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15418

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>409 DUNKIRK RD</b>		d. STREET ADDRESS <b>409 DUNKIRK RD</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNE</b> Middle <b>MARIE</b> Last <b>VANNI</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-22</b>
9. AGE (n years last birthday) <b>44</b> yrs		10. F UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Matthew J. Hughes</b>		14. MOTHER'S MAIDEN NAME <b>May E. Murphy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Elizabeth A. Cesky, Balto., Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HANGING</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.		22. DATE SIGNED <b>11-2-66</b>	
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, County, State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto., Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

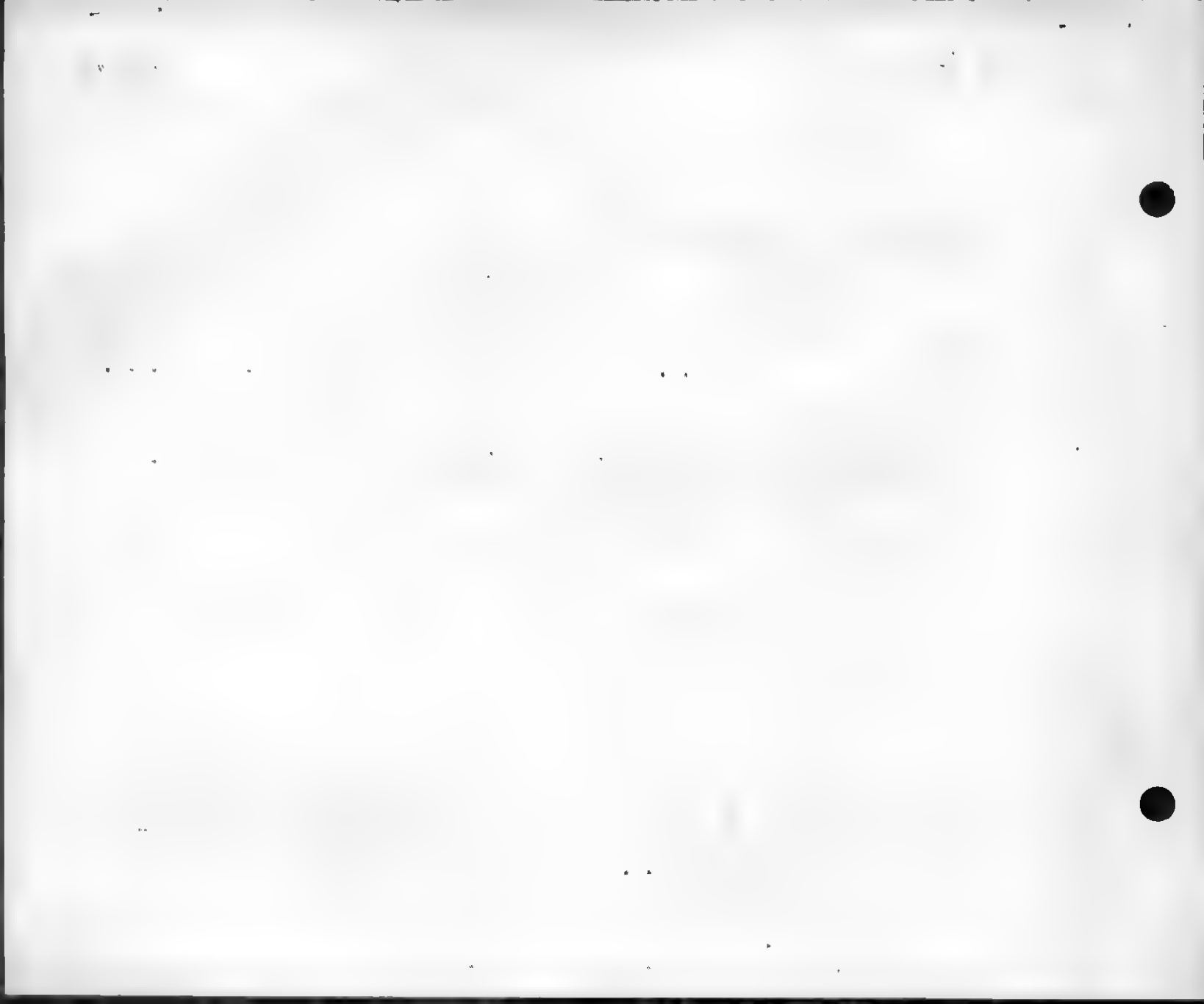
15420

15419

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>37 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>4712 HAMILTON AVENUE</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE CALLOWAY VENABLES</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 18 19 66</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08 25 95</b>
9 AGE (In years lost birthday) <b>71</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>		11. BIRTHPLACE (County & State or foreign country) <b>MARDELLA SPRINGS, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH VENABLES</b>	
14. MOTHER'S MAIDEN NAME <b>SALLIE MURPHY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>	
16. SOCIAL SECURITY NO. <b>043 01 25 71</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS, FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MYELOPHTHIC ANEMIA</b> DUE TO (c) <b>CARCINOMA PROSTATE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT 12</b> , 19 <b>66</b> to <b>NOV 18</b> , 1966, that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>NOV 18</b> , 19 <b>66</b> , and that death occurred at <b>600P M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson Neilson</i>		22b. DATE SIGNED <b>11-19-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILSON NEILSON, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov. 21, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR <b>JOHN C. MILLER</b>		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>	
FUNERAL HOME, <b>6415 BELAIR RD, BALTIMORE, MD.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.





TO HOSPITAL **IN** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may **be** retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

5421

# MARYLAND STATE DEPARTMENT OF HEALTH

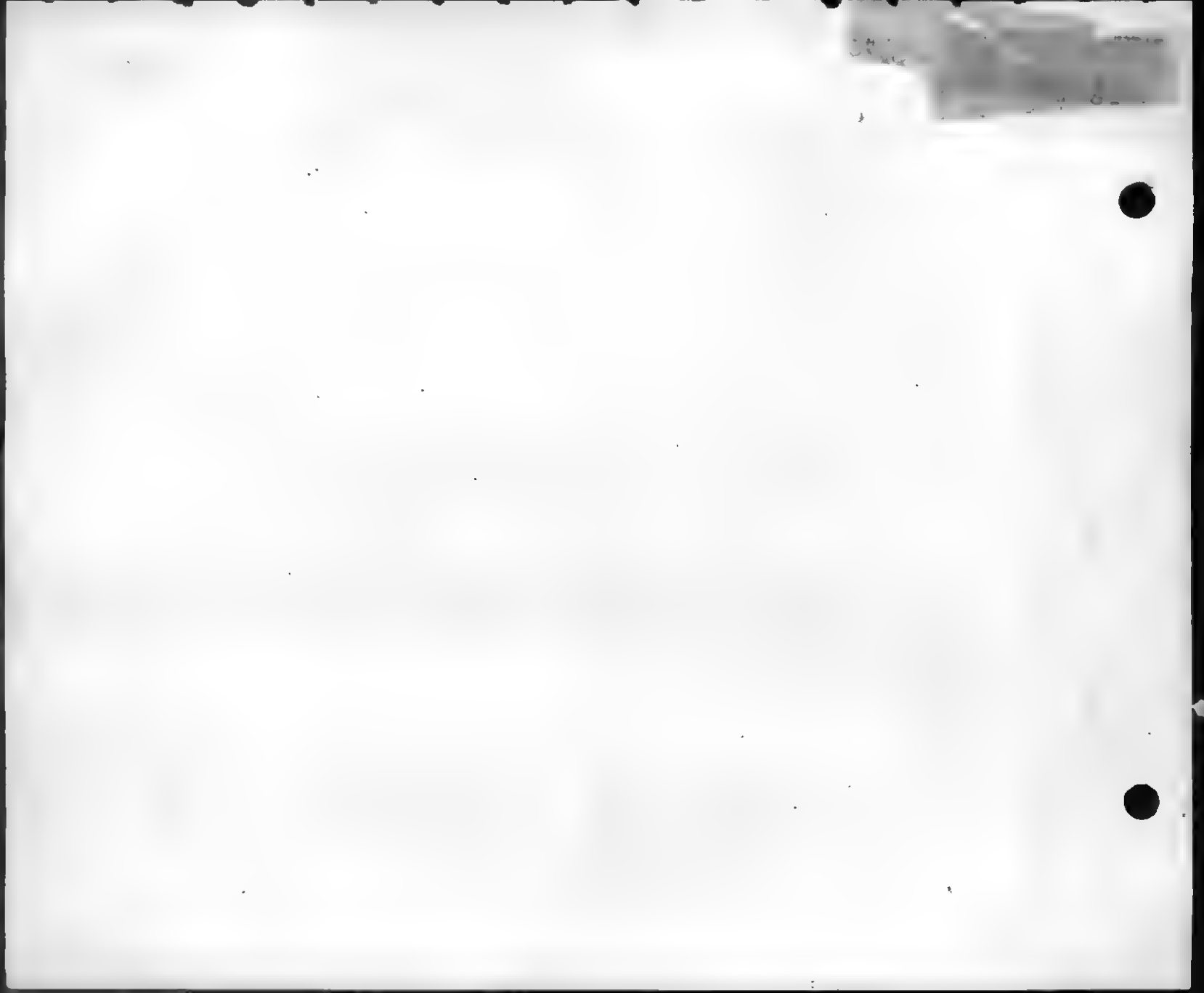
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15420

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>12 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>29 BELHAVEN DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>VERERANDA</u> First <u>MMN</u> Middle <u>MARINO</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1966</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-90</u> 9. AGE (in years last b. day) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>ENRICO MMN VERERANDA</u>		14. MOTHER'S MAIDEN NAME <u>DE CARLONIS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>213-36-7596</u> 17. INFORMANT <u>PAULINE VENERANDA</u> Address <u>29 BELHAVEN DR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the larynx +</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>11-19</u> , 19 <u>66</u> , to <u>11-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-25</u> , 19 <u>66</u> , and that death occurred at <u>6</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11-26-66</u>				22c. PHYSICIAN'S NAME (Type) <u>ENRICO B. JES M.D.</u> 22d. ADDRESS <u>GENE BALZ RD 204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		23d. LOCATION (City, town or county) (State) <u>TAKES OR AVE MD</u>	
24. FUNERAL DIRECTOR <u>DIPPEL BRO'S inc 7110 Belin Rd.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>NOV 29 1966</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15422

## CERTIFICATE OF DEATH

15421

<b>1 PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Baltimore</span> <span style="margin-left: 100px;">MARYLAND</span>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution or Residence before admission) a. STATE <span style="margin-left: 100px;">Maryland</span> <span style="margin-left: 100px;">b. COUNTY</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Towson</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Baltimore</span> <span style="margin-left: 100px;">21234</span> <span style="margin-left: 100px;">1311</span>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="margin-left: 100px;">St. Joseph Hospital</span>		d. STREET ADDRESS <span style="margin-left: 100px;">7828 Oakleigh Road</span>	
<b>3 NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 100px;">Thomas</span> Middle <span style="margin-left: 100px;">C.</span> Last <span style="margin-left: 100px;">Vianello</span>		<b>4 DATE OF DEATH</b> Month <span style="margin-left: 100px;">November</span> Day <span style="margin-left: 100px;">11</span> Year <span style="margin-left: 100px;">19 66</span>	
<b>5 SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 2-2-06
<b>9. AGE</b> (In years last birthday) <span style="margin-left: 100px;">60</span> yrs.		IF UNDER 1 YEAR <span style="margin-left: 100px;">IF UNDER 24 HRS</span> Months <span style="margin-left: 100px;">Days</span> <span style="margin-left: 100px;">Hours</span> <span style="margin-left: 100px;">Min.</span>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 100px;">Barber</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 100px;">Self-employed</span>	
<b>11 BIRTHPLACE</b> (County & State, or foreign country) <span style="margin-left: 100px;">Italy</span>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 100px;">Italy</span>	
<b>13 FATHER'S NAME</b> <span style="margin-left: 100px;">Vianello</span>		<b>14 MOTHER'S MAIDEN NAME</b> <span style="margin-left: 100px;">Vianello</span>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <span style="margin-left: 100px;">no</span>		<b>16 SOCIAL SECURITY NO.</b> <span style="margin-left: 100px;">219016666</span>	
<b>17. INFORMANT</b> <span style="margin-left: 100px;">Frances E. Vianello</span> <span style="margin-left: 100px;">same</span>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 100px;">Carcinoma of pancreas with metastases to heart</span> DUE TO <span style="margin-left: 100px;">and mesenteric lymphnodes.</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <span style="margin-left: 100px;">Partial intestinal obstruction.</span> DUE TO (c) <span style="margin-left: 100px;">Confluent bronchopneumonia, bilateral.</span>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <span style="margin-left: 100px;">19</span> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> (this hospital) attended the deceased from <span style="margin-left: 100px;">Nov. 8<sup>th</sup></span> , 19 <span style="margin-left: 100px;">66</span> , to <span style="margin-left: 100px;">Nov. 11<sup>th</sup></span> , 19 <span style="margin-left: 100px;">66</span> , that (we) last saw the deceased alive on <span style="margin-left: 100px;">Nov. 11<sup>th</sup></span> , 19 <span style="margin-left: 100px;">66</span> , and that death occurred at <span style="margin-left: 100px;">11:30 P.M.</span> from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <span style="margin-left: 100px;">D.R. Govinda Rao</span>		<b>22b. DATE SIGNED</b> <span style="margin-left: 100px;">11/12/66</span>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <span style="margin-left: 100px;">D.R. Govinda Rao, M.D.</span>		<b>22d. ADDRESS</b> <span style="margin-left: 100px;">7620 York Rd., Baltimore, Md. 21204</span>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="margin-left: 100px;">burial</span>		<b>23b. DATE THEREOF</b> <span style="margin-left: 100px;">11-15-66</span>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 100px;">Moreland Mem. Park</span>		<b>23d. LOCATION (City or Town) (County) (State)</b> <span style="margin-left: 100px;">Baltimore, Md.</span>	
<b>24 FUNERAL DIRECTOR</b> <span style="margin-left: 100px;">Leonard J. Ruck Inc Baltimore, Md.</span>		<b>25a. REC'D BY REGISTRAR</b> DATE <span style="margin-left: 100px;">NOV 15 1966</span>	
<b>25b. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 100px;">Charles Judge</span>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

15423

15422

<b>1 PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> Baltimore				<b>2 USUAL RESIDENCE</b> (When deceased lived in institution, Residence before admission) a. STATE <span style="float: right;">CALIFORNIA</span> Maryland <span style="float: right;">XXXXXXXX</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 1 yr. 6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach, California			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1000 Edmondson Avenue				d. STREET ADDRESS 2225 East 2nd Street			
<b>3 NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> Helen A. Walther				<b>4 DATE OF DEATH</b> Month Day Year November 21 1966			
<b>5 SEX</b> Female		<b>6 COLOR OR RACE</b> White		<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8 DATE OF BIRTH</b> 7-22-1886		<b>9 AGE</b> (In years last birthday) 80 yrs		<b>10 UNDER 24 HRS</b> Months Days Hours Min			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Secretary		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Baltimore		<b>11. BIRTHPLACE</b> (County & State, or foreign country) USA			
<b>13. FATHER'S NAME</b> Wilhelm Walther				<b>14. MOTHER'S MAIDEN NAME</b> Marie - Unknown			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) NO		<b>16. SOCIAL SECURITY NO</b> 212-18-4552		<b>17. INFORMANT</b> Address Martin Beerman 5322 Liberty Hghts. Ave.			
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Decompensation</i> DUE TO (b) <i>Chronic Myocarditis</i> (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 8-20-1965, to 11-21-1966, that (I) (we) last saw the deceased alive on 11-21-1966, and that death occurred at 3:50 P.M. from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Wilmer K. Gallagher</i>				<b>22b. DATE SIGNED</b> 11-22-66			
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>Wilmer K. Gallagher</i>				<b>22d. ADDRESS</b> 6209 Frederick Ave. Balto. 28, Md.			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 11-25-66		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Loudon Park Cemetery			
<b>23d. LOCATION</b> (City or Town) Baltimore, Maryland		<b>(County)</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> <i>Ellsworth Unico</i>				<b>25a. REC'D BY REGISTRAR</b> DATE NOV 23 1966			
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>				<b>4600 Liberty Hghts. Ave.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15424

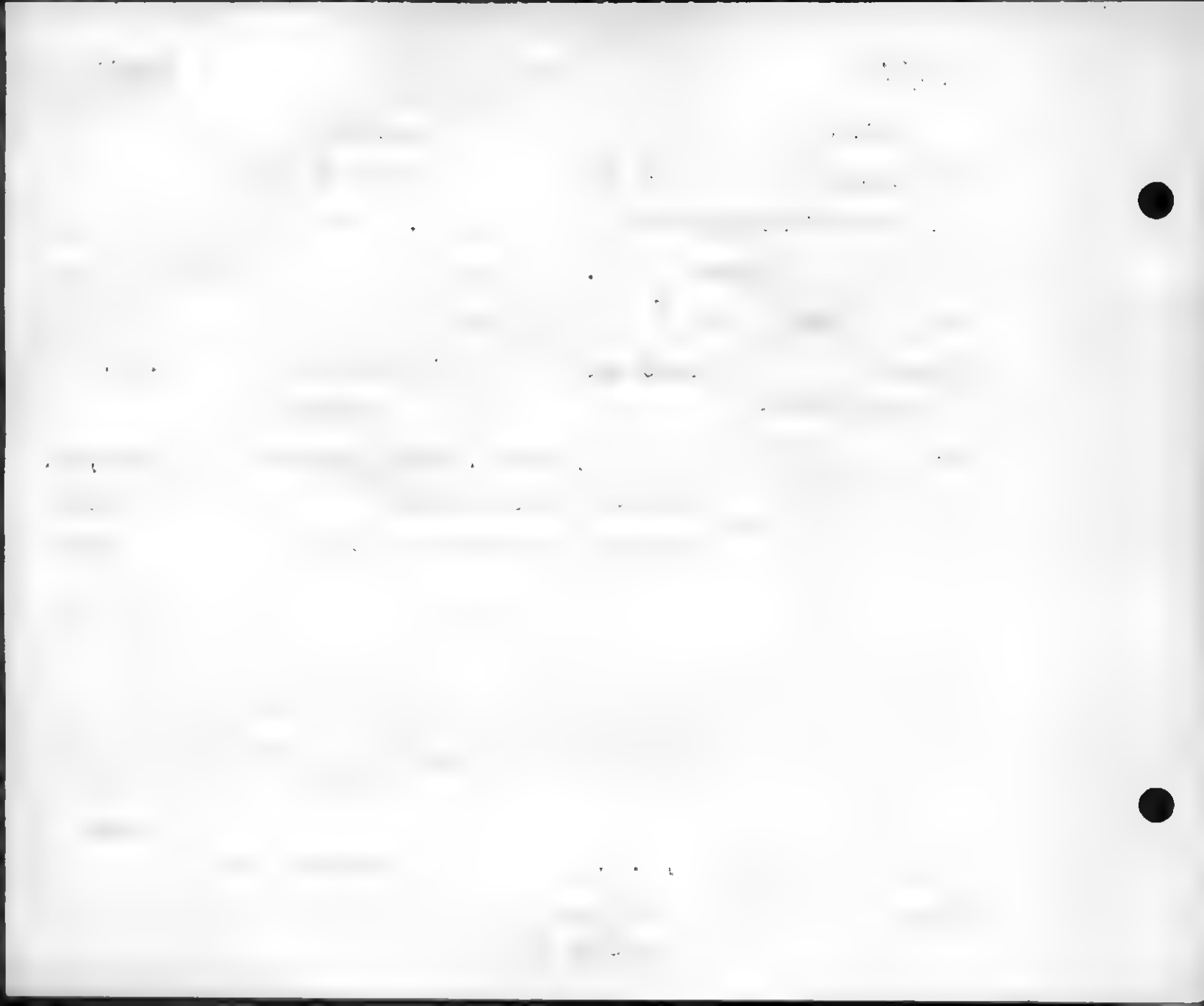
CERTIFICATE OF DEATH

15423

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>40 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>2814 W. LANVALE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>C.</b> Last <b>WELBORN</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/06</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRESSER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TAILOR SHOP</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BIRMINGHAM, ALABAMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD WELBORN</b>		14. MOTHER'S MAIDEN NAME <b>ALICE HOLOWAY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO <b>355 07 15 24</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> <del>X</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF BLADDER WITH METASTASIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>Dr</del> (this hospital) attended the deceased from <b>10/12/66</b> , 19 to <b>11/21/66</b> , 19, that <del>he</del> (we) last saw the deceased alive on <b>11/21/66</b> , 19, and that death occurred at <b>1:15A</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>11/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-25-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>WAINWRIGHT FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in final report within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

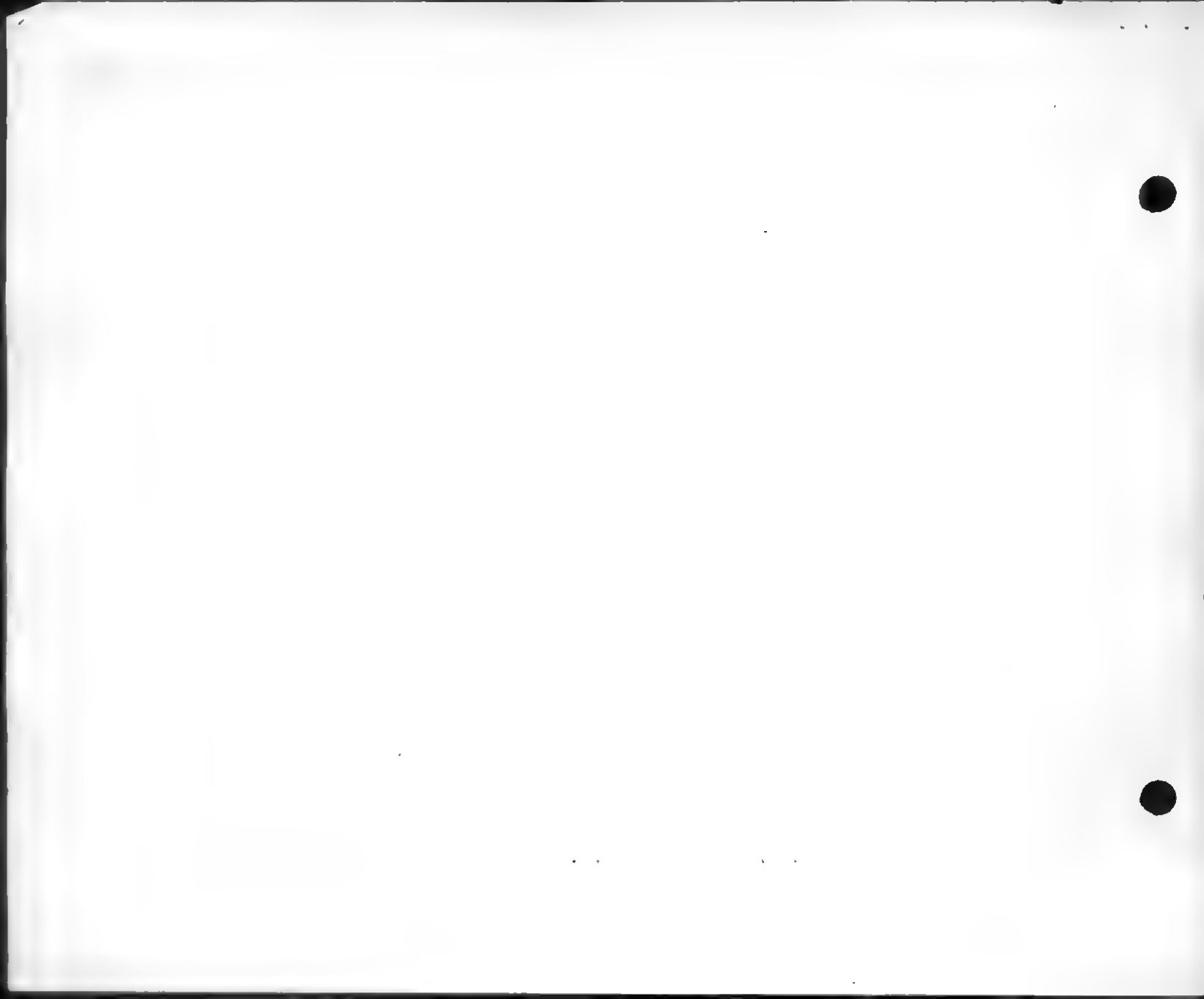
# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15425

15425

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2907 Dubois Ave</b>		d STREET ADDRESS <b>2907 Dubois Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>C.</b> Last <b>WEST</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <b>5-4-1893</b>
9 AGE (In years last birthday) <b>73 yrs.</b>		10 IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
11 U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12 KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15 FATHER'S NAME <b>John Munder</b>		16 MOTHER'S MAIDEN NAME <b>Anna Kline Fletcher</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18 SOCIAL SECURITY NO. <b>832 E Belvedere Ave</b>	
19 INFORMANT <b>Henry Munder</b>		Address <b>832 E Belvedere Ave</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422i DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>November 28, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City or town) (County) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR <b>Chas. F. Evans &amp; Son</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15426

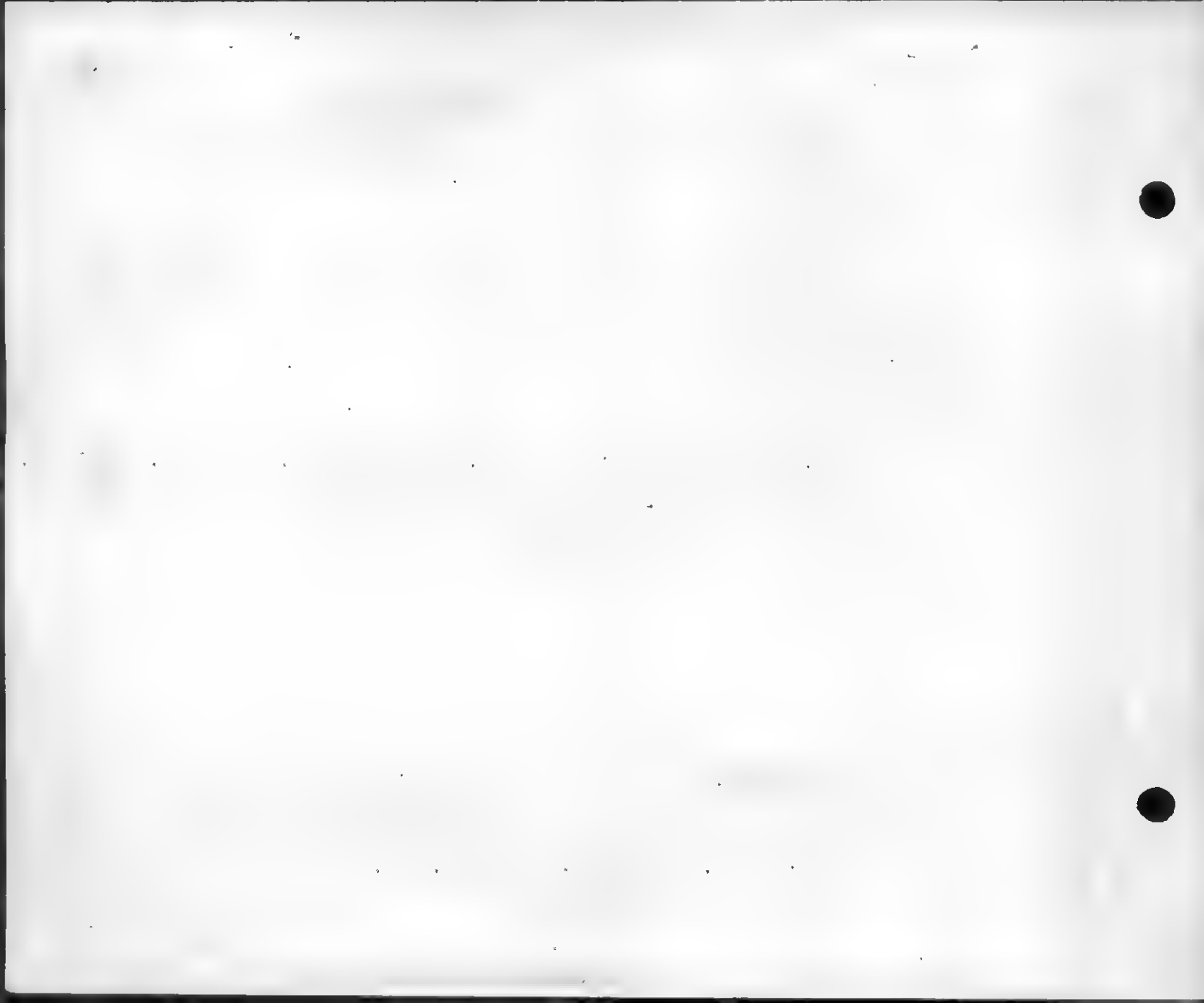
## CERTIFICATE OF DEATH

15426

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>23 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>811 GEIST CIRCLE</b>	
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>CLARK</b> Last <b>WILKERSON</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 1, 1897</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM WILKERSON</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA FORSYTHE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>218 03 63 90</b>	
17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT. 29 4-4-19 66</b> , to <b>NOV. 21 19 66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV. 21 19 66</b> , and that death occurred at <b>P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <i>Isabelita Y. Cordoba</i>		22b. DATE SIGNED <b>11 21 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ISABELITA Y. CORDOBA, M. D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., VT. HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE COUNTY, MARYLAND</b>
24. FUNERAL DIRECTOR <i>William E. Johnson</i>		25a. RECD BY REGISTRAR <b>NOV 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

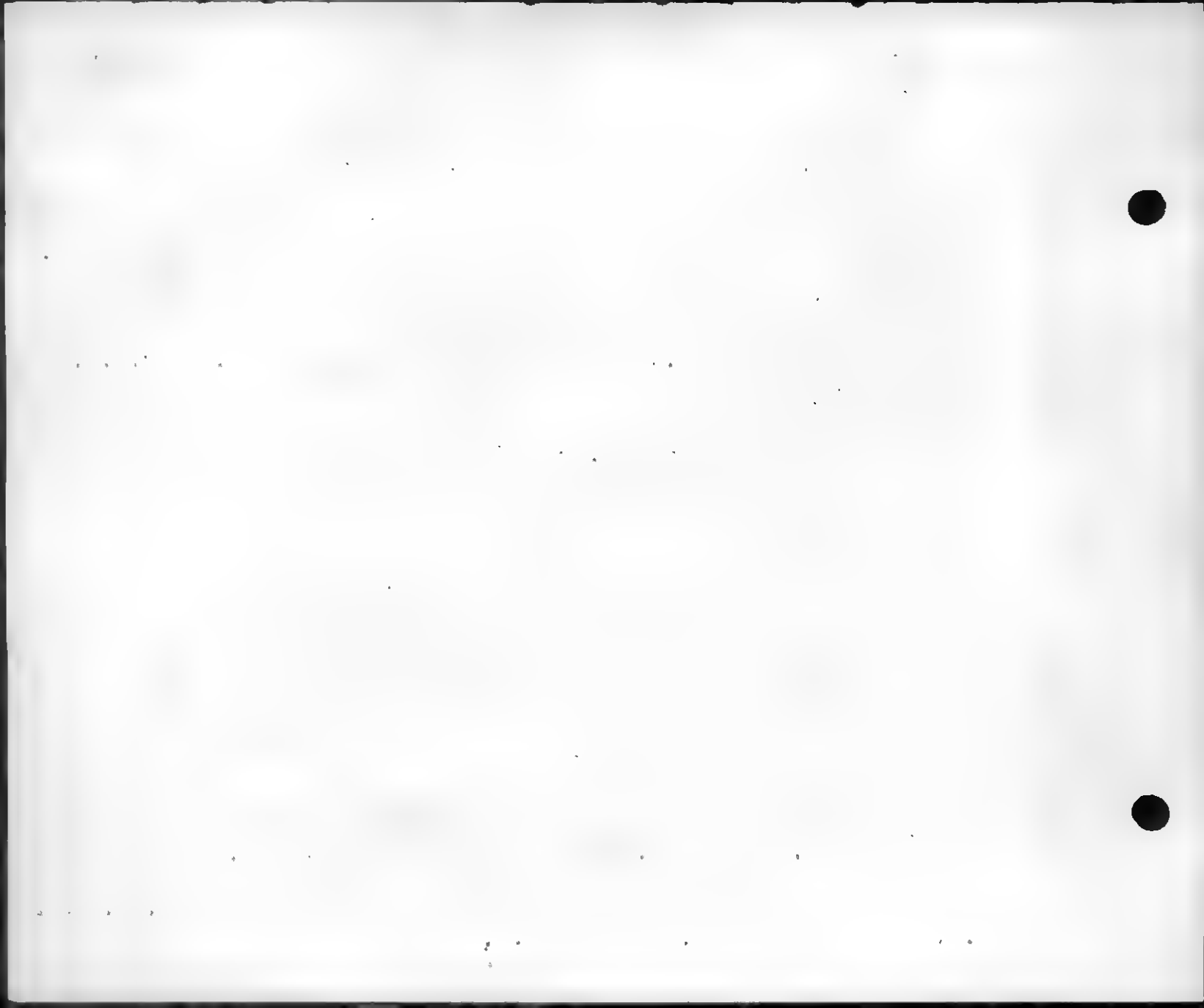


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15427					15427						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Baltimore					a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12					b. COUNTY Baltimore						
c. LENGTH OF STAY IN 1b Baltimore 12					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 513 Castle Drive					d. STREET ADDRESS 513 Castle Drive						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First George			Middle Wills			Last Wills			Month 11		
Day 24			Year 19 66			M W			W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. IF UNDER 1 YEAR		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Oct. 13, 1891			75 yrs.			Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Salesman			10b. KIND OF BUSINESS OR INDUSTRY Ins.-North American			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Wills			14. MOTHER'S MAIDEN NAME Margaret Stegman								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-10-9034-B			17. INFIRMANT Mrs. Sarah L. Wills			Address (Same)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb 1966 to Nov 1966, that (I) (we) last saw the deceased alive on Nov 24 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Dr. William G. Helfrich			22b. DATE SIGNED 11/25/1966			22c. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich			22d. ADDRESS 5006 Roland Ave.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/28/1966			23c. NAME OF CEMETERY OR CREMATORY Lorraine Park			23d. LOCATION (City, town or county) (State) Woodlawn, Balto. Co., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			25a. REC'D BY REGISTRAR NOV 28 1966			25b. REGISTRAR'S SIGNATURE Charles Judge					



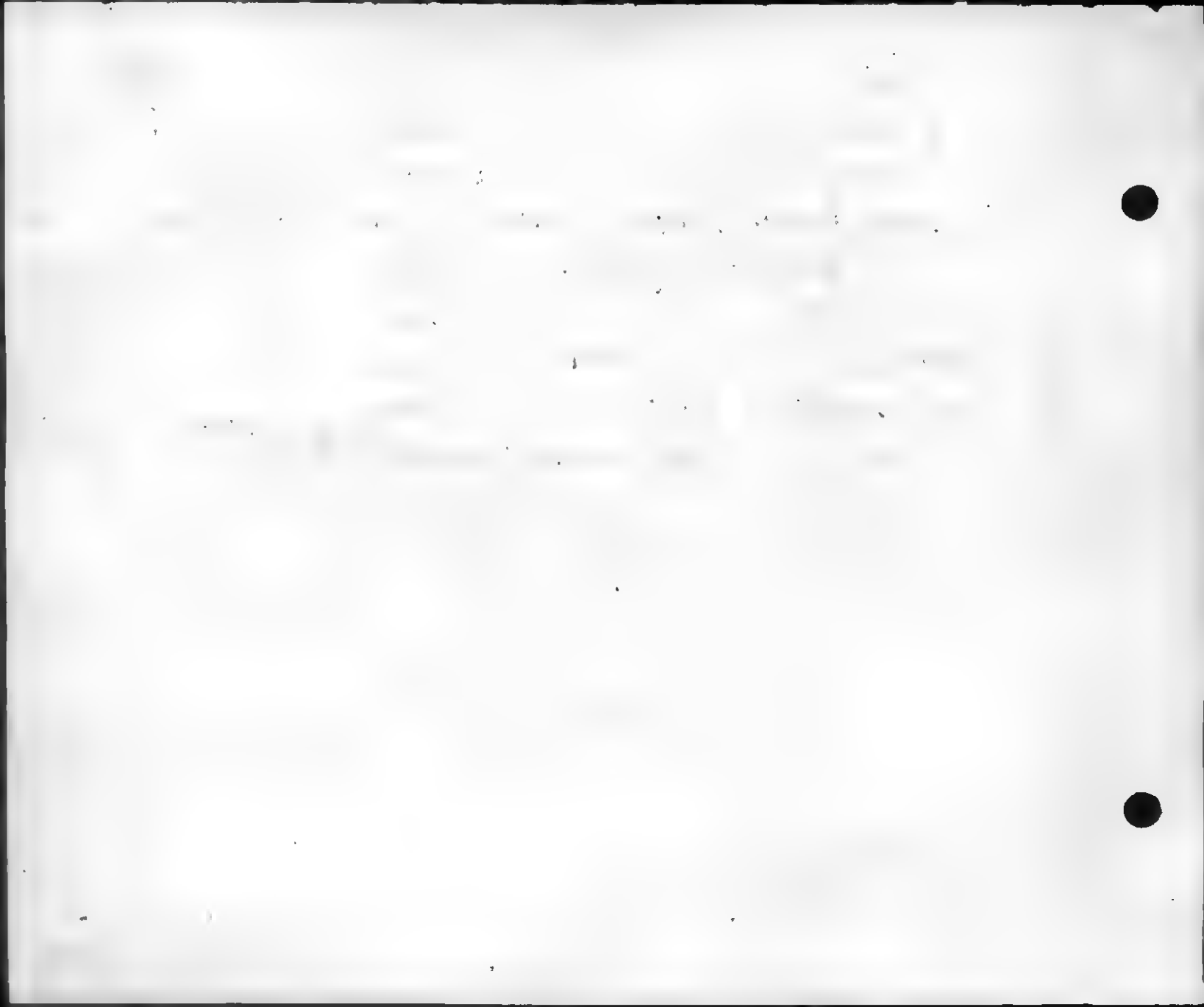
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15428						15428					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE TOWSON</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 12</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>						d. STREET ADDRESS <u>800 Ridgely Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gilbert Field Wilson</u>		First Middle Last		DATE OF DEATH <u>11 7 1966</u>		Month Day Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>11/26/00</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUDITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. of Md.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilbert Wilson</u>						14. MOTHER'S MAIDEN NAME <u>MARILETT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>312-01-738</u>		17. INFORMANT <u>MRS. MARGARET N. WILSON (SAME)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 7, 1966</u> , to <u>NOVEMBER 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 7 1966</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>E. K. S. Narayanan</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>NOVEMBER 7, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. K. S. NARAYANAN</u>						22d. ADDRESS <u>INTERN, GREATER BALTIMORE MEDICAL CENTER</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
ADDRESS <u>4905 York Road Baltimore 12, Md.</u>						DATE <u>NOV 10 1966</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15429					15429				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 21204</u> c. LENGTH OF STAY IN ID <u>71 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1805 East Joppa Road, Baltimore 34</u> d. STREET ADDRESS <u>1805 East Joppa Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Grace Oden</u> First Middle Last					4. DATE OF DEATH <u>November 15</u> 19 <u>66</u> Month Day Year				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 7, 1903</u>		9. AGE (in years) <u>63</u> yrs. <u>11</u> months <u>15</u> days <u>66</u> hours <u>15</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floral Designer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edward Oden</u>					14. MOTHER'S MAIDEN NAME <u>Claudia Wilson Oden</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>None</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dulaney Towson Nursing Home, 111 West Road</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>November, 1963</u> , to <u>Now</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/13-1966</u> , and that death occurred at <u>1:44 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>L. Myrton E. Gaines Jr.</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>L. Myrton E. Gaines Jr.</u>					22d. ADDRESS <u>7800 York Rd. Baltimore, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Parkville, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>NOV 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further necessary, please execute and affixate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

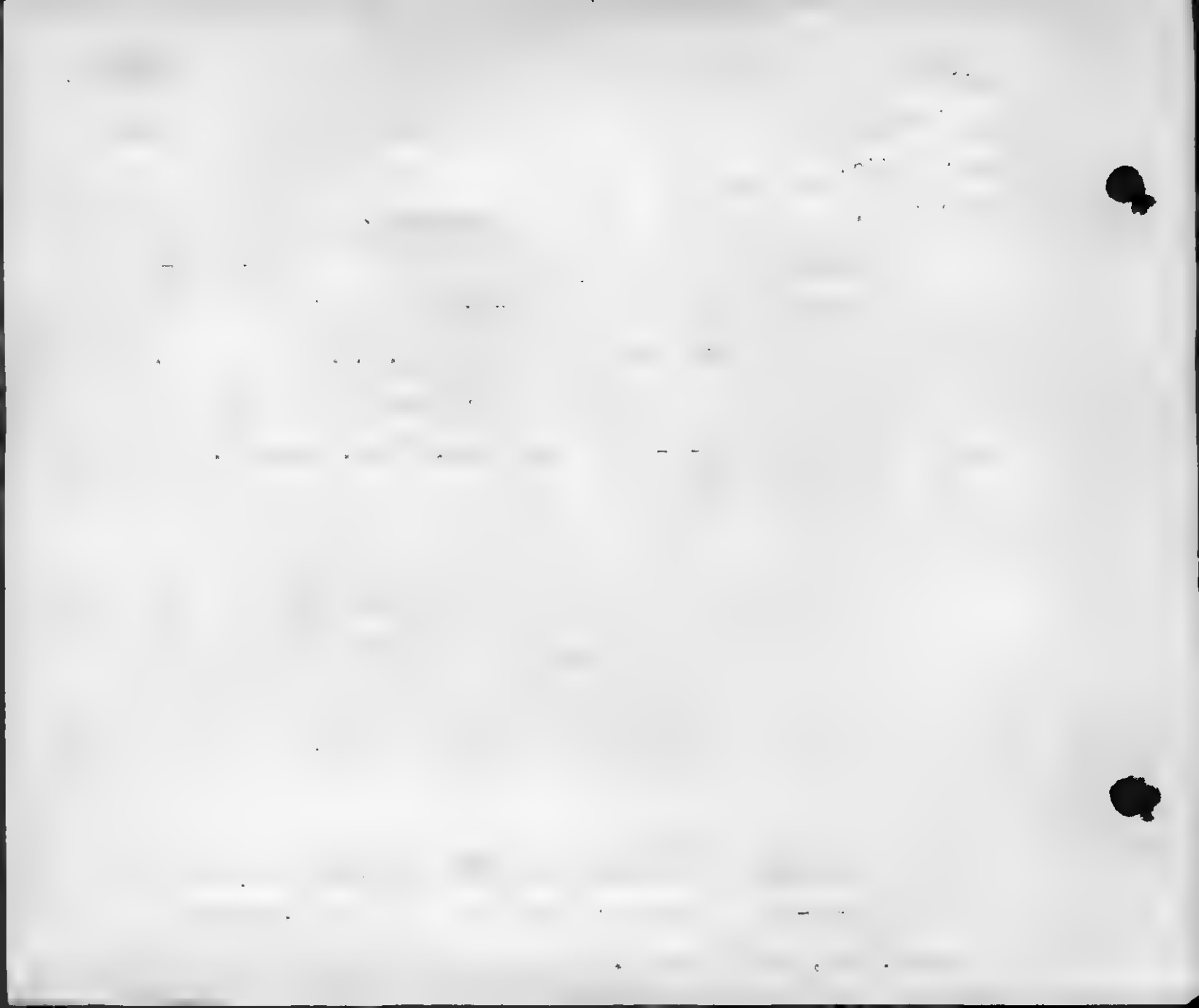
VS. AISM  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15430 15430

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>305 Main St.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u> d. STREET ADDRESS <u>305 Main St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Oscar Woods</u> b. COLOR OR RACE <u>Male</u> <u>Colored</u> c. SEX <u>Male</u> d. DATE OF BIRTH <u>6-14-95</u> e. AGE (In years, last birthday) <u>71</u> yrs. <u>11</u> months <u>25</u> days <u>19</u> hours <u>66</u> min.		<b>4. DATE OF DEATH</b> <u>11-25-66</u> a. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u> c. BIRTHPLACE (State or foreign country) <u>Chester Co. S.C.</u> d. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		<b>6. MOTHER'S MAIDEN NAME</b> <u>Mary Brown</u> b. SOCIAL SECURITY NO. <u>091-07-0909</u> c. INTERVIEWED <u>Yes</u> d. ADDRESS <u>Ruth White, 1524 N. Monroe St.</u>	
<b>7. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>A-S-C-V-DISEASE</u> Conditions, if any, which gave rise to immediate cause (b) <u>422.1</u> (a), stating the underlying cause last. (c) <u>422.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>422.1</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>8. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20b. TIME OF INJURY Month, Day, Year <u>11-30-66</u> 20c. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Baltimore, Maryland</u> 20e. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>Maryland</u>	
<b>9. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> b. CHIEF MEDICAL EXAMINER <u>M.B. Davis</u> c. ASSISTANT MEDICAL EXAMINER <u>M.D.</u> d. DEPUTY MEDICAL EXAMINER <u>Charles R. Law</u> e. ADDRESS <u>802 Madison Ave.</u>		<b>10. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> b. DATE THEREOF <u>11-30-66</u> c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> d. LOCATION (City, town, or country) <u>Baltimore, Maryland</u> e. REGISTRAR'S SIGNATURE <u>Charles R. Law</u> f. DATE <u>NOV 30 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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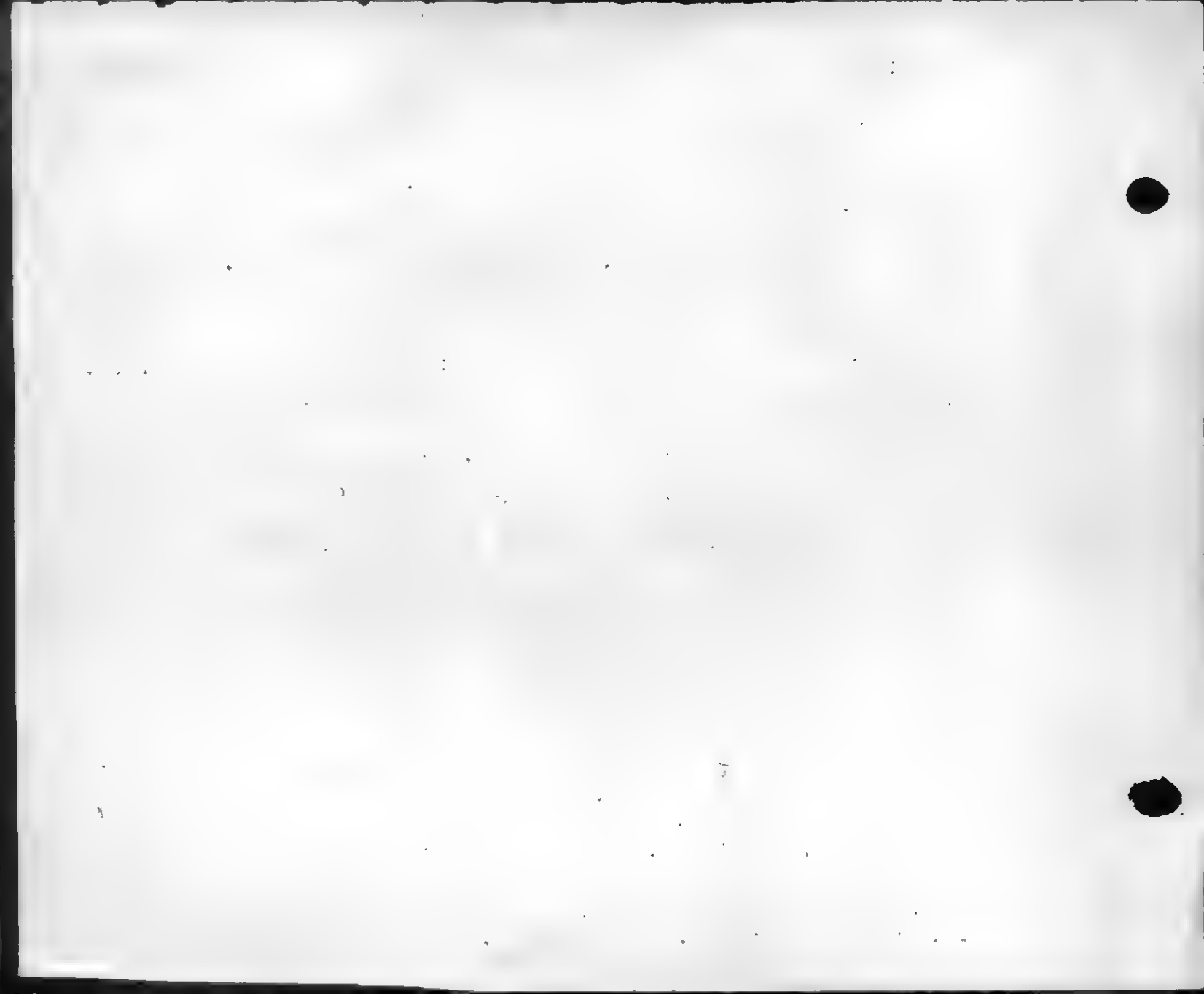
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15431

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>623 Hillen Road</b>		d. STREET ADDRESS <b>623 Hillen Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>M.</b> Last <b>Workman</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1880</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Slusser</b>		14. MOTHER'S MAIDEN NAME <b>Melinda Schrantz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>274-05-6454D</b>	
17. INFORMANT <b>Mrs. Crystal Gillespie</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident (thrombosis)</b> <b>42</b> DUE TO <b>Arteriosclerotic brain disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 18</b> , 19 <b>66</b> , to <b>Nov 2</b> , 19 <b>66</b> , that (II) (we) last saw the deceased alive on <b>Oct 31</b> , 19 <b>66</b> , and that death occurred at <b>6:05 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard N. Tillman</b>		22b. DATE SIGNED <b>Nov 2, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard N. Tillman</b>		22d. ADDRESS <b>3035 St. Paul St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Removal 11/4/1966</b>	23b. DATE THEREOF <b>11/4/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North Canton</b>	23d. LOCATION (City, town or county) (State) <b>Akron, Ohio</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15432

CERTIFICATE OF DEATH

15432

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penn.</b> b. COUNTY <b>Lancaster</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson - 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lancaster</b> <b>75.3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>2101 Birchwood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Newcomer</b> Last <b>YESSLER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-93</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Engraver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hamilton Watch</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Yessler</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Newcomer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dr. Paul G. Yessler, Silver Springs, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intra-cerebral hemorrhage</b> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>Dr. (this hospital)</b> attended the deceased from <b>Nov. 28</b> , 1966, to <b>Nov. 29</b> , 1966, that <b>X</b> (we) last saw the deceased alive on <b>Nov. 29</b> , 1966, and that death occurred at <b>2:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>Nov. 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 1, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Millersville Mennonite</b>	23d. LOCATION (City or Town) (County) (State) <b>Millersville, Pa.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1966</b>	
ADDRESS <b>1050 York Road Towson, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
15433					CERTIFICATE OF DEATH					15433									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> 13-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summit Nursing Home</b>					d. STREET ADDRESS <b>5821 Oakland Road 21227</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>E.</b> Last <b>ZINK</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>19 66</b>														
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1899</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Frank Wilger</b>					14. MOTHER'S MAIDEN NAME <b>Viola Kegg</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>NONE</b>					17. INFORMANT Address <b>Mrs. Margaret Jones, 5821 Oakland Road, 21227</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6000 Uremia</b> DUE TO (b) <b>Chronic pyelonephritis</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from <b>9/23</b> , 19 <b>66</b> , to <b>11/23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> , 19 <b>66</b> , and that death occurred at <b>4P.</b> M, from causes and on the date stated above.																			
22a. SIGNATURE <b>Herbert J. Levickas</b> M.D.					22b. DATE SIGNED <b>11/25/66</b>														
22c. PHYSICIAN'S NAME (Type) <b>Herbert Levickas</b>					22d. ADDRESS <b>1073 Maiden Choice Lane</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-26-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>												
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue, 21229</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>												

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